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Situation of and assistance to Palestinian women

Report of the Secretary-General

Summary

The present report summarizes the situation of Palestinian women between 1 September 2010 and 30 September 2011, in accordance with Economic and Social Council resolution 2011/18, and provides an overview of the assistance provided by entities of the United Nations system with regard to education and training; health; economic empowerment and livelihoods; the rule of law and violence against women; power and decision-making; and institutional development. The report concludes with recommendations for consideration by the Commission on the Status of Women.

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I. Introduction

1. In its resolution 2011/18 on the situation of and assistance to Palestinian women, the Economic and Social Council expressed deep concern about the grave situation of Palestinian women in the Occupied Palestinian Territory, including East Jerusalem. It requested the Secretary-General to continue to review the situation, to assist Palestinian women by all available means, including those laid out by the Secretary-General in his previous report on the situation of and assistance to Palestinian women (E/CN.6/2011/6), and to submit to the Commission on the Status of Women at its fifty-sixth session a report, including information provided by the Economic and Social Commission for Western Asia (ESCWA), on the progress made in the implementation of the resolution.

2. The present report covers the period from 1 September 2010 to 30 September 2011 and reviews the situation of Palestinian women based on information from United Nations entities or individual experts that monitor the situation of Palestinians in the Occupied Palestinian Territory.

3. Unless indicated otherwise, the report is based on contributions and information submitted by entities of the United Nations system that provide assistance to Palestinian women, including ESCWA, the United Nations country team for the Occupied Palestinian Territory and the Office of the United Nations Special Coordinator for the Middle East Peace Process. The United Nations country team has coordinated contributions to the report by the following United Nations entities: the Food and Agriculture Organization of the United Nations (FAO), the International Labour Organization (ILO), the Office for Coordination of Humanitarian Affairs, the Office of the United Nations High Commissioner for Human Rights (OHCHR), the United Nations Conference on Trade and Development (UNCTAD), the United Nations Development Programme (UNDP)/ Programme of Assistance to the Palestinian People, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the United Nations Office for Project Services, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), the World Food Programme (WFP) and the World Health Organization (WHO).

II. Situation of Palestinian women

4. During the reporting period, little progress was made in the efforts to reach a negotiated agreement between Israel and the Palestinians on all core issues which would end the conflict and the occupation that began in 1967. Progress was hampered by continuing low levels of confidence between the parties and in the political process. Direct peace talks began on 2 September 2010 but stalled the following month and have not resumed since. International efforts, in particular through the Middle East Quartet, have continued to encourage the parties to overcome the current obstacles and resume direct bilateral negotiations without preconditions, expecting them to come forward with comprehensive proposals on security and territory. The Secretary-General has called upon both parties to refrain from provocation and to work with the Quartet towards serious proposals on borders

and security in the context of a shared commitment to resume direct negotiations that would lead to an agreement on all final status issues.

5. Amid these developments, the Palestinian Authority continued its efforts to strengthen the State institutions of a future Palestinian State and resumed its efforts towards reuniting the West Bank and Gaza. However, little progress was accomplished in implementing the reconciliation accord of 4 May 2011 between the Palestinian factions, and the internal Palestinian divide continued to restrict the ability of the Palestinian Authority to extend its State-building work to Gaza (see A/66/80-E/2011/111, para. 10).

6. At the beginning of the sixty-sixth session of the General Assembly, in 2011 the Palestinian leadership applied for full membership in the United Nations and called upon Member States to recognize a Palestinian State within the 1967 borderlines. The Government of Israel expressed its strong opposition to such Palestinian action (see A/66/367-S/2011/585, para. 13). At the time of the drafting of the present report, the Palestinian application for United Nations membership was before the Security Council. While women have played important roles in promoting peace in the region, few women have been directly involved in the negotiations since the start of the conflict and have also largely remained absent from official discussions on statehood and related actions in the United Nations.[1]

7. On the ground, the overall socio-economic, political and humanitarian situation in the Occupied Palestinian Territory remained challenging and continued to adversely affect the situation of Palestinian women. In Gaza, Israel's June 2010 policy decision to ease the closure and further measures taken since brought some limited relief to the population. However, owing to the pivotal nature of the remaining restrictions and the magnitude of the existing challenges, overall, these measures remained ineffective in achieving a genuine improvement in the humanitarian situation.[2] The population of the Gaza Strip remained severely affected by sporadic upsurges of violent conflict between armed Palestinian militants and the Israel Defense Forces, in addition to the continuing closures that penetrate every aspect of socio-economic life. It is estimated that approximately 20,000 girls and boys remain displaced in the aftermath of the 2009 military operation on Gaza, while 80 per cent of households have at least one member suffering from psychosocial symptoms.[1] The West Bank continues to face a protracted crisis resulting from the ongoing confiscation and annexation of Palestinian land, settlement construction, demolitions of houses and livelihood structures, forced evictions, the revocation of residency rights and obstructed access to land, markets and essential services.[1]

8. During the reporting period, there was an increase in settlement construction, house demolition and evictions of Palestinian families. A total of 544 structures in Area C of the West Bank and East Jerusalem were demolished, marking a significant increase from the previous year. Among the structures demolished were 180 residences, resulting in over 980 people displaced, including approximately 525 children. Overall a total of 14,636 people have been affected by the demolitions. Palestinian construction is effectively prohibited in some 70 per cent of

[1] Contribution of the United Nations country team in the Occupied Palestinian Territory to the present report.

[2] Office for the Coordination of Humanitarian Affairs, *Special Focus: Easing the Blockade: Assessing the Humanitarian Impact on the Population of the Gaza Strip* (March 2011).

Area C, in areas that have been confiscated for use by Israeli settlements or the Israel Defense Forces. In the remaining 30 per cent of Area C where Palestinian construction is not prohibited, there are a range of other restrictions that greatly reduce the possibility of obtaining a building permit. As a result, Palestinians needing to build in Area C are often left with no other choice than to build without a permit and risk the demolition of their structures.[3]

9. Palestinian women continued to be victims of violence resulting from the Israeli-Palestinian conflict. Reports indicate that there was an increase in the indiscriminate firing of rockets, mortars and other munitions on Israel by Hamas and other militant groups as well as in the frequency of Israeli strikes in Gaza, resulting in civilian deaths and injuries (see A/66/80-E/2011/111, para. 13). According to the Office for the Coordination of Humanitarian Affairs, Israeli forces killed three Palestinian women, two in the Gaza Strip and another in the West Bank, and injured 151 others, including 17 in the Gaza Strip and 134 in the West Bank, where there were also 23 women injured by Israeli settlers. In the West Bank, including East Jerusalem, women sustained injuries, mainly during weekly demonstrations against actions by the Israeli military, clashes between Palestinians and Israeli forces in East Jerusalem and in search-and-arrest operations.[1] This marks an increase in casualties and injuries of women compared to last year during which one Palestinian woman was killed in Gaza (none in the West Bank) and another 86 were injured by Israeli forces and 13 others were injured by Israeli settlers.[4]

10. In the Gaza Strip, OHCHR received information on the increasing intervention by the de facto authorities in the restriction of civil rights and freedoms, including the right to peaceful assembly, and further restrictions on the access to leisure places, including the closure of some of them, under the pretext of mixing of the sexes and non-compliance with the Islamic customs. On 15 and 16 March 2011, two demonstrations in favour of national unity took place in Gaza City. De facto security forces forcibly dispersed the demonstrations, reportedly beating the participants. Over 50 women were beaten by the security forces, including 8 girls, who were briefly detained, beaten with sticks and verbally insulted by approximately 10 security personnel in civilian clothes and police uniforms.[5]

11. As of May 2011, there were still 29 Palestinian women[6] held in detention and prison by the Government of Israel outside the Occupied Palestinian Territory in violation of international humanitarian law obligations. The overall living conditions of Palestinian women in Israeli prisons were reported as unchanged. The conditions in penal institutions in which women were detained, including the poor quality of food, limited fresh air and sunlight, dirty overcrowded cells, were said to contribute to the weakening of the physical and psychological condition of women. Released women prisoners continue to face reintegration problems.[1]

12. Poverty, unemployment and food insecurity rates have remained high. In Gaza, the unemployment rates were at 47.8 per cent for women and 36.2 per cent for

[3] Ibid., *Special Focus: Displacement and insecurity in Area C of the West Bank* (August 2011).

[4] Ibid., Protection of Civilians: Casualties Database, 1 September 2010-1 August 2011.

[5] OHCHR closely monitored the demonstration.

[6] Office for the Coordination of Humanitarian Affairs, *The Monthly Humanitarian Monitor* (June 2011).

men.[7] In the period from November 2010 to April 2011, export volumes reached only 5 per cent of the pre-June 2007 levels and no exports have been transferred out of Gaza since May 2011.[8] The exhaustion of commercial opportunities and subsequent devastation of the Gazan economy has meant that many households have lost their incomes, and it is estimated that 38 per cent of Gazans are living in poverty and that 75 per cent of Gazan households are dependent on humanitarian assistance.[9] In the West Bank, the total poverty rate is 18 per cent, of which 9 per cent are considered deeply poor.[10] There is a decrease in real wages by 6.4 per cent, comparing the first half of 2009 to the first half of 2010,[11] while the purchasing power decreased, as the inflation rate increased by 2.98 per cent between the average prices of July 2010 versus July 2011.[12]

13. Even if there was a slight improvement in overall food security, 2010 estimates show that 36 per cent of female-headed households and 33 per cent of male-headed households in the Occupied Palestinian Territory were food insecure. Most of these are chronically food insecure. In the Gaza Strip, the prevalence of food insecurity among both female- and male-headed households was higher, at 48 and 52 per cent, respectively. However, in both the West Bank and the Gaza Strip, households with a higher number of female adult members are more likely to be food insecure, owing to limited access to job opportunities and lower salaries for women. Overall, female-headed households typically have a lower food consumption score, with 38 per cent having a poor or borderline dietary intake compared to 28 per cent among male-headed households.[13]

14. A significant number of Palestinian women were outside of the formal labour force, engaged in unpaid domestic work, or were working within the informal sector. It is estimated that 38.3 per cent of women working in the informal sector in the Occupied Palestinian Territory are unpaid family members, compared to 9.2 per cent of men.[14] Recent research by UN-Women on the Gaza Strip shows that women

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[7] Palestinian Central Bureau of Statistics, "Labour Force Survey, 2011", Ramallah, 2011, cited in the contribution of the United Nations country team in the Occupied Palestinian Territory to the present report.

[8] WPF, *World Food Programme, Occupied Palestinian Territory Situation Report*, May-June 2011, available from www.ldf.ps/documentsShow.aspx?ATT_ID=4251.

[9] Office for the Coordination of Humanitarian Affairs, Fact sheet, humanitarian situation in the Gaza Strip (July 2011).

[10] Palestinian Central Bureau of Statistics, "Poverty and living conditions in the Palestinian Territory, 2009-2010", Ramallah, 2010, cited in the contribution of the United Nations country team in the Occupied Palestinian Territory to the present report.

[11] UNRWA, "West Bank labour market: a briefing on the first-half 2010".

[12] Palestinian Central Bureau of Statistics, "Monthly consumer price index numbers by major groups for the months of January-December 2010 and per cent changes from January-December 2009", available from www.pcbs.gov.ps/Portals/_pcbs/cpi/dd634faf-669e-448b-a96a-3a64cb824f9a.htm; and "Monthly consumer price index numbers by major groups of expenditure for the months of January-July 2011 and per cent changes from December 2010", available from www.pcbs.gov.ps/Portals/_pcbs/cpi/9013200f-427b-464c-a3fe-462ae224a527.htm, cited in the contribution of the United Nations country team in the Occupied Palestinian Territory to the present report.

[13] FAO, WFP and the Palestinian Central Bureau of Statistics, "2010 Socio-economic and food security survey, West Bank and Gaza Strip, Occupied Palestinian Territory" (2010).

[14] Palestinian Central Bureau of Statistics, "Informal sector and informal employment survey, October-December 2008: main findings", Ramallah, 2011, cited in the contribution of the United Nations country team in the Occupied Palestinian Territory to the present report.

play critical roles in securing their households' livelihoods after a decline in income of the male breadwinner. However, the economic burden of the protracted crisis tends to impoverish women even more. Women's contributions to sustain the family's livelihood, such as heavy work on the family's agricultural holdings and liquidating personal assets, such as gold or inherited land, have not strengthened women's status in the community, but have contributed instead to their marginalization.[15] Women's entrepreneurship continues to be constrained by the lack of access to local and international markets. Rural women, especially younger women, of which many live in Area C, face a number of obstacles owing to their isolation and lack of mobility.[16] According to FAO, in 2010, the work of an estimated 40 per cent of rural Palestinian women of working age (15-64 years) was unpaid and unaccounted for in national accounts.[17]

15. Women's health remains another area of concern. The persistence of disease and illness is exacerbated, both directly and indirectly, by persistent obstacles to Palestinian movement, including checkpoints and access to health and other services, such as water and sanitation. The impact of the occupation and the overall insecure situation have contributed to psychological trauma and increased stress among women, men and children. The poor quality of water continues to cause problems of parasites, diarrhoea and skin diseases and it is estimated that over 90 per cent of water in Gaza is unfit for human consumption owing to increased levels of chlorides and nitrates.[18] In the West Bank, over 113 communities, including more than 150,000 women, are not connected to water networks, while those that are connected face frequent severe water shortages owing to depleted springs and wells.[1] In Gaza, hospitals and clinics continue to be affected by severe shortages in medical supplies, power cuts, delays in shipments, overcrowding and insufficient doctor-patient time.[1]

16. Few official health statistics are sex-disaggregated and most are limited to basic morbidity and mortality figures, reproductive health indicators and cancer statistics. According to WHO, chronic diseases such as cardiovascular and cerebrovascular diseases and cancer, with only slight differences between males and females, were the main causes of death, with breast cancer being the leading cause of cancer morbidity among women. Fertility rates in the Occupied Palestinian Territory, in particular in the Gaza Strip, remain high, resulting in the need and demand for related health-care services. Micronutrient deficiencies in the Occupied Palestinian Territory continue to be a major concern, with high rates of anaemia among pregnant women and children. Results of the 2010 Family Survey indicated that more than one quarter of pregnant women were anaemic (26.7 per cent of pregnant women aged 15-49: 39.1 per cent in the Gaza Strip and 15.4 per cent in the West Bank).[19] Access to proper and timely health care can enhance early detection and treatment of disease and improve mother and child health. For example, the

[15] UN-Women, "Who answers to Gazan women? An economic security and rights research" (2011).

[16] Contribution of ESCWA to the present report.

[17] FAO, *Palestinian Women's Associations and Agricultural Value Chains, Rural Employment, Case Studies Series # 2* (Rome, 2010).

[18] UNRWA, "Promoting long and healthy lives in Gaza" (2011), available from www.unrwa.org/userfiles/2011031723858.pdf.

[19] Palestinian Central Bureau of Statistics, "Family Survey", Ramallah, 2010, cited in the contribution of the United Nations country team in the Occupied Palestinian Territory to the present report.

identified causes of maternal and infant deaths suggest that many of them could have been prevented by more effective antenatal, childbirth and early postnatal health care.[20]

17. Although the overall quality of education available to women in the Occupied Palestinian Territory remains variable, access to and participation in education by women and girls has continued to increase. At present, the Occupied Palestinian Territory ranks in the medium range (76 out of 128) of the Education for all Development Index.[21] During the 2010/11 academic year, girls represented 51 per cent of the total student population. In the West Bank and in the Gaza Strip, 31,352 girls (58.2 per cent) and 105,015 girls (48 per cent), respectively were enrolled in UNRWA elementary and preparatory education. However, many challenges remain. In the Gaza Strip, the limited reconstruction of schools damaged in 2009 continues to prevent thousands of boys and girls from accessing basic education. According to UNICEF, overcrowded schools operate on a double-shift basis, stretching their capacity to its limits. The number of adolescents (both boys and girls) falling below their grade level and dropping out of school is on the rise, and only 75 per cent of students continue into secondary school.[1]

18. In Area C, according to the Office for the Coordination of Humanitarian Affairs, 18 schools had outstanding demolition orders in August 2011, as a result of the lack of building permits.[22] Access to education is further hampered by Israeli settler violence as well as by restrictions on Palestinian access and movement. An additional factor for remote communities is the high cost of transport to educational facilities. Some families living in isolated locations pay up to NIS 100 per child per month on school transport. Families with several children of schooling age are often forced to choose only one or two, frequently boys, to complete their education, while the others are withdrawn from the system after the primary years. Such factors have led to high dropout rates, particularly among girls.[3] In East Jerusalem, a shortage of over 1,000 classrooms leaves approximately 12,000 children out of the education system. According to UNICEF, many schools in the West Bank suffer from water shortages and lack separate or suitable toilets for girls and boys, a situation that is usually affecting school attendance for girls, especially in secondary school. Progress made with regard to girls' and women's access to and participation in education has not necessarily translated into decent employment opportunities for women. For those with higher education, women's unemployment is significantly higher than men's. In 2011, 39.2 per cent of women with 13 or more years of education were unemployed, compared to 13.1 per cent for men.[23]

19. Although women have played numerous roles within the Palestinian political system and served in key decision-making positions, their formal participation and representation in decision-making, including in governance and legislative bodies, has overall been limited. In the current Government, women represent 20 per cent of

[20] WHO, Health conditions in the Occupied Palestinian Territory, including East Jerusalem, and in the occupied Syrian Golan, report by the Secretariat (A/64/27) of 16 May 2011.

[21] UNESCO, *Education For All Global Monitoring Report: The hidden crisis: Armed conflict and education* (Oxford: Oxford University Press, 2011).

[22] Office for the Coordination of Humanitarian Affairs, *Humanitarian Fact Sheet on Area C of the West Bank*, July 2011.

[23] Palestinian Central Bureau of Statistics, "Labour Force Survey, April-June 2011", Ramallah, 2011. Press release available from www.pcbs.gov.ps/Portals/_pcbs/PressRelease/LabourForce_q2e.pdf.

the ministers and 6 per cent of the deputy ministers and they account for 12.9 per cent of the Palestinian Legislative Council. Within all ministries, women comprise 30.6 per cent of the staff. In the ministries of women's affairs and of social affairs, women are the majority, comprising 68.1 per cent and 56 per cent of all staff, respectively. Additionally, women account for 11 per cent of all judges, 12 per cent of all prosecutors, and 11 per cent of all lawyers.[24] In 2010, the first Palestinian woman governor was appointed to serve as Governor of the Ramallah and al-Bireh Governorate. Despite many shared concerns and priorities, the political situation and the split between political factions has contributed to divisions among women and made coordination more challenging, including in terms of formulating common positions by women's groups from the West Bank and Gaza in issues related to the State-building process. On the ground, however, women's organizations have continued to support women and girls from all walks of life, including by providing direct services and empowering women through livelihoods projects; serving as charitable organizations, providing training to the police and security forces to be more sensitive to survivors of violence; and undertaking research and advocating for women's rights and legal reform.[16]

20. The disadvantaged situation of Palestinian women has been exacerbated by weak rule of law and gender-based discrimination that remains embedded in legislation, regulations and policies. The situation is further complicated by the existence of two legal systems in the Gaza Strip and the West Bank and the lack of access to legal protection for Palestinian women in East Jerusalem. In addition, the prevailing gender stereotypes and norms continue to limit women's freedom of movement, access to employment, health care and education and the exercise of other human rights.[1]

21. High levels of poverty, unemployment and related frustration have contributed to an increase in tension, and ultimately violence, within families. According to data collected by the Palestinian Central Bureau of Statistics, the level of domestic violence against women and girls in the Occupied Palestinian Territory is high.[25] At present, there is no specific law on domestic violence in place, and there continues to be a critical lack of systems capable of preventing violence, protecting victims and prosecuting perpetrators. In addition, the fear of stigma, social exclusion and retribution, including in the form of more harm, risk of divorce and separation from children, prevent many women from speaking out about abuse.[1]

22. Some positive steps have been taken. On 11 January 2011, the Palestinian Cabinet endorsed the National Strategy to Combat Violence against Women (2011-2019). The strategy, which includes inputs from a range of sources, including women's organizations, civil society, community organizations, the private sector, ministries and women refugees, takes a cross-sector approach, recognizing violence against women as a development issue affecting the social, economic and political systems of Palestinian society. Efforts have also been made to address crimes against women committed under the guise of so-called "family honour", which still continue to occur. On 15 May 2011, in response to one such case in the Hebron area,

[24] Palestinian Central Bureau of Statistics, "Women and men in Palestine, 2010" (2011). Ramallah cited in the contribution by the United Nations country team in the Occupied Palestinian Territory to the present report.

[25] Contributions of ESCWA and of the United Nations country team in the Occupied Palestinian Territory to the present report.

the Palestinian Authority President signed a presidential decree removing provisions within the Penal Code that provided for leniency with regard to murder in the name of "family honour", which will come into effect once it is published in the Palestinian Official Gazette.[1]

23. The Palestinian Cabinet, together with the Ministry of Planning and Administrative Development, tasked the Ministry of Women's Affairs to develop a cross-sectoral national gender strategy for the period 2011-2013, with the purpose of placing gender equality and women's empowerment at the core of the 2011-2013 Palestinian National Plan. The three-year Strategy,[26] which was endorsed by the Council of Ministers in January 2011, highlights multiple challenges Palestinian women face and serves as a reference for developing gender-responsive policies that would positively influence the socio-economic and political conditions of both women and men.

III. Assistance to Palestinian women

24. The political and socio-economic insecurity in the Occupied Palestinian Territory continues to have a severe humanitarian impact. Despite some recent macroeconomic improvements, the humanitarian, economic and development needs remain significant. The needs and related priorities, including of women and girls, are reflected in several documents, including the Consolidated Appeals Process for 2011, which set out a strategy budgeted at $575 million, the UNRWA medium-term strategy for 2010-2011, which was estimated at $675 million, excluding emergency relief interventions, and the Palestinian National Development Plan 2011-2013, which outlined priority development needs worth $4.161 billion (see A/66/80-E/2011/111, para. 3). The inclusion of a gender marker in the Consolidated Appeals Process for 2011 and the deployment of an Inter-Agency Standing Committee Gender Standby Capacity Adviser during its development period resulted in significantly higher levels of information related to gender equality in project documents than in the Consolidated Appeals Process for 2010.[1]

25. The present section provides information on efforts made by the United Nations system, in cooperation with the Palestinian Authority, donors and civil society, to address the needs and priorities of women and girls. It provides information on assistance provided in six key areas: education and training, health, economic empowerment and livelihoods, rule of law and violence against women, power and decision-making and institutional development.

A. Education and training

26. United Nations entities continued to implement a wide range of initiatives to improve the access of women and girls to quality education and training. These actions include the provision of free basic education, transportation to and from school, scholarships, vocational and literacy training, as well as measures to support a better transition from education and training to women's economic empowerment and job opportunities. In the West Bank and in the Gaza Strip, Palestinian girls

[26] Available from www.unwomen.org/wp-content/uploads/2011/05/UN-Women-oPt-Booklet-Palestinian-Gender-Strategy-2011-en.pdf.

continued to benefit from basic education provided free of charge by UNRWA with strong achievements in terms of gender parity and girls' performance. A total of 24 female students benefited from UNRWA-administered scholarships for universities in the West Bank and 755 female students benefited from technical and vocational training at the Ramallah Women's Training Centre. The UNRWA Gender Initiative provided adult literacy training in Arabic and English to 7,925 women and information technology training to 1,773 women in the Gaza Strip. It also provided mobile literacy support to reach women living in remote areas. Increased efforts were taken to provide graduates of the Gender Initiative with the necessary skills and experience to enter the job market. In the Gaza Strip, the UNRWA relief and social services programme offered work experience and skills training to 1,092 women through women's programme centres, where vocational trainings in areas such as sewing, hairdressing, handicrafts, and information technology literacy were taught.

27. UNICEF increased learning opportunities for at least 100 girls in remote communities in Area C through the rehabilitation of school classrooms. In addition, UNICEF offered after-school learning and recreational activities in adolescent-friendly centres to 6,000 adolescent girls in marginalized areas in the West Bank (including East Jerusalem) and the Gaza Strip. OHCHR, together with UNICEF, the Education and Protection clusters and with the Ministry of Education and Higher Education worked to improve girls' access to education by providing school transportation for isolated Bedouin communities in the Bethlehem and Hebron governorates, thus reducing the dropout rate and allowing the safe access of female students to education.

B. Health

28. The United Nations system continued to provide a wide range of health services to Palestinian women and girls. In its effort to increase access to health care across the West Bank, UNRWA established five mobile clinics, which provided regular preventative and curative health care for 13,000 Palestinian patients facing restrictions on their mobility, 66 per cent of whom were women and children. UNFPA continued to support two multi-purpose women's health centres providing a holistic range of services, including clinical services, legal advice, counselling services on gender-based violence, psychosocial support, physiotherapy, gymnastics, and health education to 20,000 female beneficiaries living in heavily populated and underprivileged areas in Gaza (Jabalia, Bureij) and the West Bank (Hebron).

29. UNRWA, WHO and UNICEF implemented various measures aiming at improving maternal and child health. In the West Bank, UNRWA provided antenatal care to 7,893 pregnant women, post-natal care to 5,593 women and family planning services to 23,731 women during the first two quarters of 2011. In the same period 9,453 women were referred to hospitals where they received advanced treatment. In the Gaza Strip, the number of pregnant women receiving antenatal care reached 24,750 and all 8,187 deliveries over the first half of 2011 received post-natal care. Pregnant women and nursing mothers living in isolated rural communities in the Gaza Strip, including Bedouins, benefited from home medical visits provided by UNRWA. Following the expansion of a WHO project to ensure quality maternal and newborn health in the six hospitals in the Gaza Strip, the rate of early discharge for

mothers was reduced, thereby improving post-natal care and reducing risk to women and newborn babies. Additionally, WHO has begun piloting a programme to increase the midwifery capacity among health-care professionals. To address rising micronutrient deficiencies among women and children, UNICEF launched the Baby-Friendly Hospital Initiative to promote infant feeding practices among mothers. Additionally, UNICEF is supporting a national micronutrient survey to accurately monitor the micronutritional status of women and children.

30. A range of psychosocial services were also provided. For example, from October 2010 to June 2011, a total of 29,281 beneficiaries, of whom 62 per cent were female and 37 per cent below the age of 18, received counselling through the UNRWA community mental health programme. Over that same period, 86,937 refugees, of whom 58 per cent were female and 50 per cent were below the age of 18, benefited from community-based group activities and awareness sessions in the area of mental health. In December 2010, WHO held a workshop on the topic "Child and maternal mental health in the Gaza Strip", which brought together local academics and mental health professionals to address ways of integrating mental health into existing services, with a particular focus on the impact of military attacks on the mental health of women and children. Each month, approximately 2,000 girls and 1,000 mothers benefited from protection and psychosocial services in 20 family centres supported by UNICEF across the Gaza Strip, aimed at strengthening their coping skills. In addition, group and individual counselling benefited hundreds of children and their caregivers in affected communities in both the West Bank and the Gaza Strip.

31. UNICEF provided approximately 28,000 girls in 40 primary schools in the Gaza Strip with improved access to safe drinking water through water tankers. The rehabilitation of water, sanitation and hygiene (WASH) facilities in 27 schools is expected to improve access to safe water and sanitation for roughly 14,000 girls and 550 female teachers. The continued rehabilitation of water networks in the south of the West Bank resulted in 3,000 women and girls and their families having access to safe drinking water through water networks for the first time.

32. Within the framework of a five-year HIV joint programme implemented in the Occupied Palestinian Territory, UN-Women presented the research on the topic "Exploring dynamics and vulnerabilities of HIV transmission among sex workers in the Palestinian context" at the High-Level Meeting of the General Assembly on AIDS, held in New York in June 2011.

C. Economic empowerment and livelihoods

33. Socio-economic indicators confirm the continuing need to invest in economic empowerment, livelihood and food security. Assistance by United Nations entities in this area includes different forms of financial assistance, capacity-building, emergency job creation as well as direct food assistance. Female-headed households continued to be a specific target group for many entities.

34. UNRWA remains one of the main employers of women, particularly in the extremely limited labour market of the Gaza Strip. In addition, UNRWA offers women short-term employment opportunities through its emergency job-creation programme. Between 1 September 2010 and 31 July 2011, a total of 17,424 women in the West Bank received work through the programme. Tools, materials and

equipment, such as sewing machines, fabrics and thread for the production of embroidery items were provided to participating women's centres all over the West Bank. In the Gaza Strip, as of mid-August 2011, women held 6,840 out of a total of 24,317 positions created through the programme. Through the "women-run school canteens" project, funded by Norway and in partnership with the Ministry of Education and Higher Education, UN-Women has been able to continue to provide women's centres with a sustainable income. By preparing the meals for the school canteens, 26 women's centres have become financially independent, are providing an income for the women working with them and are also providing healthy meals to the schoolchildren.

35. To provide short-term poverty alleviation, UNRWA continued its efforts to offer relief to special hardship cases in the West Bank and in the Gaza Strip, including through cash assistance. A high number of the beneficiaries were female. In addition, UNRWA provided emergency cash assistance for shelter repair to female-headed households in the Gaza Strip and the West Bank. UNRWA also implemented various measures to support longer-term livelihood strategies, including through the provision of financial services. From 1 September 2010 to 31 July 2011, 14 per cent of the loans in the West Bank were given to women clients. During the same period in Gaza, UNRWA disbursed a total of 1,071 business loans to female beneficiaries, amounting to $1,379,700 and a total of 167 non-business loans valued at $574,100 to support the housing and consumer needs of female-headed households. With a special emphasis on women-headed households, UNDP/Programme of Assistance to the Palestinian People strengthened activities under the Deprived Families Economic Empowerment Programme, which works to improve the living conditions and economically empower the most deprived Palestinian families, through accessing a package of financial and non-financial services. It is estimated that 1,400 women benefit from the 35 per cent of projects run by women under the Programme.

36. ILO, UNDP, UNESCO and UN-Women provided various forms of capacity-building, technical and other support to promote the economic empowerment of women. ILO, in cooperation with the Union of Cooperative Associations for Savings and Credit, provided members of 40 women-only cooperatives across the West Bank with grants, training and technical assistance. ILO also piloted a capacity-building programme targeting over 200 Palestinian women microentrepreneurs to introduce and showcase the ILO Gender and Entrepreneurship Together (GET Ahead) training methodology. In addition to enhancing employment opportunities for women, this ILO initiative served the broader purpose of building the capacities of business development service institutions to provide gender-responsive services. Through the Joint Programme on Gender Equality and Women's Empowerment in the Occupied Palestinian Territory, run by the Millennium Development Goals Fund, UNESCO, UNDP and UN-Women have supported initiatives such as the community-based production and marketing of arts and crafts by women artisans and women's involvement in ecotourism.

37. FAO has continued its work to improve food and economic security through projects targeting female-headed households. Activities include home gardens, livestock units, aquaculture, food processing, marketing, improving water management and support to women associations. Approximately one third of FAO beneficiaries in the West Bank and Gaza Strip are women. Women and food-insecure female-headed households are a primary target group of the FAO three-year

Plan of Action (2011-2013) for the West Bank and Gaza Strip. Female-headed households are also an explicit target group for WFP in both the West Bank and Gaza Strip and are prioritized throughout all food distribution programmes. Some 35,651 women had a ration card from WFP in the reporting period. In most cases, they are also targeted by complementary interventions such as cash assistance. Food assistance provided by UNRWA reached 10,244 female-headed households in the West Bank and 7,650 in the Gaza Strip.

D. Rule of law and violence against women

38. During the reporting period, United Nations entities continued to promote women's access to justice and implement a range of measures to address violence against women. Through its Rule of Law and Access to Justice Programme, UNDP/Programme of Assistance to the Palestinian People supported civil society organizations providing Palestinian women with legal aid and assistance, including in divorce cases, and, in conjunction with the Palestinian Bar Association, supported the establishment of a network of female lawyers. Additionally, women going through divorce benefited from a financial assistance programme administered through the Palestinian Maintenance Fund. UNRWA provided legal advice and support to 3,341 women through legal advice bureaux based in women's programme centres. A range of awareness-raising classes on cultural, health and social issues were also provided at these centres. OHCHR undertook many activities to promote women's rights in both the West Bank and the Gaza Strip, including public information and awareness-raising activities and training on relevant standards of international human rights law and international human rights procedures for staff of women's rights organizations.

39. The United Nations Office for Projects Services designed and constructed a gender-sensitive prison and detention facility in the West Bank, allowing female inmates full movement and use of facilities, while providing privacy and separation from male prisoners. This marked significant progress in the care and rehabilitation of female inmates in the Occupied Palestinian Territory. UN-Women provided a full support package of regular weekly social, psychological and legal assistance to women inmates in the three Palestinian reform and rehabilitation centres, which included primary need goods to female inmates with newborn babies. In conjunction with the Independent Commission for Human Rights, UN-Women helped to ensure the reporting of violations against female inmates, improved monitoring of inmate conditions and the filing of complaints or requests for actions to the relevant authorities.

40. On behalf of several donors and the Ministry of the Interior, the United Nations Office for Projects Services also implemented the expansion of a police training centre in the West Bank, which has resulted in a comprehensive and modern training facility for almost 600 cadets, including both male and female students. Special consideration has been given to the gender perspective in all new buildings, with a particular emphasis on dormitory buildings, the learning centre and the gymnasium to ensure the equal participation and education of female cadets.

41. Various entities, including OHCHR, UNESCO, UNFPA, UNRWA and UN-Women, continued to implement various initiatives to raise awareness and enhance capacity among practitioners to prevent and respond to violence against

women. UNFPA developed guidance and provided training to social workers and health-care providers on ways of responding to the needs of victims of violence and implemented awareness-raising initiatives targeted at groups such as rural women and religious leaders. UNRWA organized capacity-building workshops for their health-care staff to help them to identify and address cases of domestic violence in their health centres. Capacity-building workshops on the prevention of domestic violence were also held for community members in refugee camps and for community-based organizations. UN-Women supported a public awareness campaign that included daily radio features, and awareness-raising workshops reaching 2,051 people in the Gaza Strip. Within the framework of the "16 Days of Activism Against Gender Violence" global campaign, United Nations entities supported the organization of festivals to combat violence against women in Ramallah and in the Gaza Strip, attracting more than 600 and 700 people, respectively.

42. A range of initiatives aimed to increase the access to services for women and girls survivors of violence. For example, acting under the umbrella of the Ministry of Social Affairs, UN-Women continued to support the Mehwar Centre in Bethlehem, the first multiservice centre providing shelter, psychosocial counselling, health, legal aid and empowerment opportunities. Building on this experience, a new multi-purpose centre — the Hayat Centre — was established in the Gaza Strip. UN-Women also continued to support the Sawa Helpline for survivors of violence against women. UNRWA established family and child protection committees in nine refugee camps in the West Bank to bring community representatives, leaders and organizations together with the UNRWA health, education and social services departments to lead the implementation of a comprehensive multisectoral approach to combating violence against women. Efforts are also under way to develop referral systems for women victims of violence. UNRWA established five one-stop centres providing health services, legal advice and psychosocial counselling to survivors of violence and UNRWA frontline staff are being trained to refer and counsel survivors of violence. UNFPA continued to support three community-based coalitions that provide psychosocial counselling and help in establishing various community-based initiatives focusing on women's empowerment.

43. A number of entities provided institutional support to efforts to address violence against women, including domestic violence. This included support by UN-Women to the development of the National Strategy to Combat Violence against Women (2011-2019) and support by UNDP/Programme of Assistance to the Palestinian People and UNFPA to the Palestinian Central Bureau of Statistics to implement the 2011 Palestinian Domestic Violence Survey, which will provide key baseline information for policy, planning and tracking of progress in addressing domestic violence. UNESCO organized a series of training workshops for approximately 400 women in the Occupied Palestinian Territory, including parliamentarians, on analysing data and statistics on violence against women, which resulted in the development of an action plan by participants linked to the National Strategy to Combat Violence against Women (2011-2019). ILO contracted the Palestinian Central Bureau of Statistics and the Birzeit University Institute of Women's Studies to jointly conduct a study on the gender dimensions of violence in the world of work.

E. Power and decision-making

44. A number of United Nations entities implemented activities such as workshops, trainings and awareness-raising initiatives to promote women's participation in decision-making and leadership. UNDP/Programme of Assistance to the Palestinian People organized a two-day workshop in July 2011 to support dialogue on the kind of State that would best deliver to women, which linked together women from all over the Occupied Palestinian Territory. The aim of the workshop was to give Palestinian women a space to voice their concerns and opinions on a future Palestinian State, to learn from experiences of women in State-building efforts in other transitional societies, and to propose approaches that women could take in the coming months to ensure that their opinions are reflected in public debates. In the Gaza Strip, UNDP provided training in leadership, empowerment and entrepreneurship to 52 women leaders of the administrative committees of community-based organizations. UN-Women, in partnership with the Women's Affairs Technical Committee, organized awareness-raising activities on women's political participation and leadership for 1,136 participants representing a cross-section of civil society groups.

F. Institutional development

45. A number of United Nations entities, including ILO, FAO, UNDP/Programme of Assistance to the Palestinian People, UNESCO, UNFPA and UN-Women have continued to support various ministries, such as the Ministries of Women's Affairs, Agriculture, Social Affairs, Labour, Culture and Youth and Sports, to mainstream gender perspectives into their areas of work and improve the monitoring of progress in promoting gender equality and the empowerment of women, including through sector-specific technical support, the secondment of gender equality experts in ministries and efforts to improve capacities for gender-based analysis and data collection. As part of the roll out of the implementation of the Cross-Sectoral National Gender Strategy for 2011-2013, UN-Women supported the Ministry of Women's Affairs in the organization of its first ever international donor meeting with the aim of seeking support for the implementation of the three-year strategy.

46. ILO organized rounds of training and extensive participatory gender audits, after which the creation of a national audit team was announced by the Ministry of Women's Affairs. The team will continue to work through action plans, developed in consultation between ILO and its tripartite constituents, thereby effectively addressing the gender gaps detected in the audits.

47. ILO also assisted in the establishment of a national women's employment committee. The committee, which was endorsed by the Minister of Labour on 24 March 2011, will assist the Ministry of Labour and social partners in implementing specific measures to promote women's employment and their protection in the workplace. In July 2011, ILO met with the Minister of Labour to follow up on a study entitled "Review of labour laws to promote women's labour force: a legal analysis and recommendations for promoting gender equality", conducted in 2010 in consultation with the Ministry of Labour and the national women's employment committee. The study puts forward suggestions for future revisions of the Palestinian Labour Law.

48. Both UNDP/Programme of Assistance to the Palestinian People and UNFPA supported enhanced attention to gender equality and youth priorities and the engagement of young women in decision-making. UNDP/Programme of Assistance to the Palestinian People worked closely with the Ministry of Youth and Sports and local civil society organizations to support the drafting of the Palestinian Youth Sector Strategy 2011-2013 Document, including by ensuring the active participation of young women and men from the West Bank (including East Jerusalem) and the Gaza Strip in the process.

49. The UNESCO Palestinian Women's Research and Documentation Centre provided training to women leaders of organizations in developing indicators to measure organizational effectiveness and supported the Ministries of Women's Affairs and Culture in the development of gender-sensitive indicators. In addition, 21 participants from the gender units of different ministries were provided training in gender issues as well as management, planning, advocacy, monitoring and evaluation.

50. Initiatives targeted at the United Nations system were also implemented. For example, the UNRWA Gaza Women's Committee has provided services and training to women employees to improve their day-to-day work life and assist them in exploring future opportunities to develop themselves professionally. UN-Women continued to provide technical assistance and gender training to other United Nations entities working in the Occupied Palestinian Territory on ways to mainstream gender equality perspectives at all stages of programming and policy formation.

IV. Conclusions and recommendations

51. **The overall political, humanitarian, security and socio-economic situation in the Occupied Palestinian Territory remained challenging. The stalled peace process, escalation in tensions between the parties, increased settlement activity, the internal Palestinian divide and continued outbreaks of violence are causes of serious concern. Improving the situation of Palestinian women remains closely linked to efforts to find lasting peace. It is critical to ensure Palestinian women's full and equal participation in conflict-resolution and mediation efforts as well as in the statehood dialogue, so that they, along with men, shape the future direction of their society in accordance with the global commitments set out in instruments such as the Beijing Declaration and Platform for Action and Security Council resolutions 1325 (2000), 1820 (2008), 1888 (2009), 1889 (2009) and 1960 (2010).**

52. **During the reporting period, United Nations entities continued to assist Palestinian women and girls in a multitude of ways, including by providing education and health, improving access to safe water, creating employment opportunities, including emergency employment, supporting their longer-term livelihood and economic empowerment through financial and other measures, such as training and capacity-building, and by improving food security. Female-headed households continued to be a main target group for many entities. The United Nations system has also assisted in efforts to strengthen institutional and policy development and the rule of law and, in particular, to improve the prevention and response to violence against women. Access to basic**

services, however, is still inadequate for all Palestinians, in particular women and girls, and high levels of unemployment, poverty and insecurity persist. Continued support and increased investment across all these areas remain a critical need.

53. **Over the past year, important achievements have been made in policy development. The launch of the Cross-Sectoral National Gender Strategy for 2011-2013 and the National Strategy to Combat Violence against Women (2011-2019) and the initial steps taken to implement them are encouraging. These strategies serve as important tools to address the urgent needs and priorities of women and girls, to tackle gender-based discrimination in law and in practice, to prevent all forms of violence against women, including domestic violence, and to protect women and girls from such violence. Promising work was also undertaken to bring more attention to gender equality issues in the development of the 2011-2013 Palestinian Youth Sector Strategy Document and in discussions regarding revisions of the Palestinian Labour Law. The effective implementation of these strategies requires sustained political commitment, technical support and financial resources.**

54. **Socio-economic indicators reveal that there is a serious need to continue to invest in women's economic empowerment, livelihood and food security. Women's economic empowerment is a necessity for women's political empowerment but also for the overall development and growth of the Palestinian economy and society. The Palestinian Authority, United Nations entities and other stakeholders should continue to develop and implement measures in support of women's access to and control over resources, training and the creation of employment opportunities for women.**

55. **Enhanced efforts should be taken to systematically incorporate information on the situation of women and girls in studies, reports and briefings by the United Nations system and by independent experts related to the Occupied Palestinian Territory, and this information should also be brought to the attention of the relevant intergovernmental bodies. It is also essential to continue efforts to strengthen the capacity of the United Nations system to incorporate gender equality perspectives into the planning and implementation of assistance programmes to ensure that the different needs, priorities, capacities and contributions of women, men, boys and girls are fully recognized and addressed and the entities continue to provide targeted assistance to women and girls.**

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Release of women and children taken hostage, including those subsequently imprisoned, in armed conflicts

Report of the Secretary-General

Summary

The present report is prepared in response to the request contained in resolution 54/3 of the Commission on the Status of Women on the release of women and children taken hostage, including those subsequently imprisoned, in armed conflict. It is based on contributions from Member States. It also provides information on attention given to issues related to the topic in intergovernmental processes.

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I. Introduction

1. At its fifty-fourth session, in 2010, the Commission on the Status of Women adopted resolution 54/3 on the release of women and children taken hostage, including those subsequently imprisoned, in armed conflicts. Recalling its previous resolutions on the topic, the Commission continued to express its grave concern at the continuation of armed conflicts in many regions throughout the world and the human suffering and humanitarian emergencies they cause. The Commission recalled relevant provisions contained in the instruments of international humanitarian law relative to the protection of the civilian population as such, as well as relevant resolutions of the General Assembly and the Security Council, including on the prevention of armed conflict, on women and peace and security and on children and armed conflict.

2. The Commission, inter alia, called for the immediate release of women and children taken hostage, including those subsequently imprisoned in armed conflicts. It urged States that are parties to an armed conflict to take all necessary measures, in a timely manner, to determine the identity, fate and whereabouts of women and children taken hostage and to provide safe, unimpeded access to humanitarian assistance for those women and children, in accordance with international humanitarian law. The Commission stressed the need to put an end to impunity and the responsibility of all States to prosecute, in accordance with international law, those responsible for war crimes, including hostage-taking. The Commission invited the special rapporteurs with relevant mandates, as well as the Special Representative of the Secretary-General for Children and Armed Conflict, to continue to address the issue of women and children taken hostage, including those subsequently imprisoned, in armed conflicts. It also requested the Secretary-General and all relevant international organizations to use their capabilities and undertake efforts to facilitate the immediate release of civilian women and children who had been taken hostage.

3. The Secretary-General was requested to submit to the Commission at its fifty-sixth session a report on the implementation of resolution 54/3, including relevant recommendations, taking into account the information provided by States and relevant international organizations. The present report is prepared in response to that request. It is based on information received from Member States. It also provides information on attention given to issues related to the topic in intergovernmental processes.

II. Information from Member States

4. In preparation of the report, a request was sent to Member States to provide information regarding the status of implementation of resolution 54/3. The Governments of the Dominican Republic, Iraq and the Sudan provided information in response to that request.

5. The Government of the Dominican Republic emphasized that it attaches great importance to the eradication of all forms of violence, especially violence against women. Although the Dominican Republic had not experienced armed conflict for four decades, all specialized personnel in charge of protecting civilians in case of conflict and extreme situations must undergo trainings on human rights and

international human rights law. The Government acknowledged the gravity of gender-based violence and its pernicious effects on society. The Ministry of Women collaborates with several government institutions in designing strategies to prioritize women's security and ensure that the justice system and special response units adequately address gender-based violence.

6. The Government of Iraq reported that the issue of hostage-taking as an illegitimate act that violates human rights had been addressed in the Anti-Terrorism Law, No. 13 of 2005, and the Iraqi Penal Code, Law No. 111 of 1969. The Government of Iraq appreciates that every person has the right to enjoy all the rights and freedoms set forth in the international instruments and that children, in particular, are in need of special care and assistance. Iraq is a party to the Convention on the Rights of the Child and the two Optional Protocols thereto and the Geneva Conventions. Pursuant to Law No. 85 of 2011, Iraq acceded to the Protocol Additional to the Geneva Conventions relating to the Protection of Victims of International Armed Conflicts, and deposited the instrument of accession with the Secretary-General. Pursuant to Law No. 17 of 2009, Iraq signed the International Convention for the Protection of All Persons from Enforced Disappearance. The Government of Iraq is continuing to build and strengthen respect for human rights and the rule of law, which represent the most important challenges currently facing Iraq. The Government of Iraq noted that the acts of violence that have taken place since 2003 have contributed to an increase in cases of kidnapping and hostage-taking.

7. The Government of the Sudan stressed that it ascribed great importance to the resolution of armed conflicts. For decades the Sudan has been plagued by armed conflicts, most of which have been resolved through dialogue and peace agreements. In seeking to resolve conflicts, the Government of the Sudan reported that it had exerted considerable efforts to establish the underpinnings of just peace and reduce the impact of conflict on civilians, giving special priority to women and children. Information was provided on legal frameworks for protection, including international instruments to which the Government is a party and national legislation. Articles concerning: unlawful detention; crimes against humanity; the detention of persons or deprivation of their physical liberty by any other means; the detention and forced impregnation of a woman with the intention of influencing the racial structure of any population group; the kidnapping or detention of any person in the name of a State or political organization and approval of or complicity therein; and the prohibition of the detention or taking hostage in any way of any person who is subject to protection are included in the Penal Code. Article 15 (b) of the 2007 Armed Forces Act outlaws the unlawful detention, enforced disappearance or deprivation of the liberty of any person. Article 44 of the 2010 Child Act provides that former child soldiers should be demobilized and reintegrated into society and the economy.

8. The Government of the Sudan reported that it had no record of any women or children having been taken hostage in the areas of armed conflict that are under Government control. The Government coordinates with relevant institutions to ensure the release of women and children that are held hostage in areas under the control of armed movements. Humanitarian assistance is provided for citizens affected by armed conflict by relevant authorities, in coordination with the specialized agencies of the United Nations, the international community and national and international voluntary organizations. A draft policy on the empowerment of women and a National Strategy for the Elimination of Violence

against Women have been formulated. In addition, a number of mechanisms have been established to improve protection of women and children. These include the establishment of family and child protection units managed by the police, a special unit for the elimination of violence against women and children attached to the Council of Ministers and the Security Council resolution 1612 (2005) Working Group on Children and Armed Conflict, which provides for a monitoring and reporting mechanism on children and armed conflict and facilitates systematic dialogue and the exchange of information between the Government and the United Nations on this topic.

III. Attention given to issues related to the topic in intergovernmental processes

9. Since the previous report to the Commission (E/CN.6/2010/5), attention has been given to issues related to the topic of the present report in various intergovernmental bodies, including the General Assembly, the Security Council and the Human Rights Council. This involved, inter alia, analysis of information on enforced disappearances; missing persons; hostage-taking linked to terrorism and maritime piracy; and children and women forcibly recruited into, or abducted by, armed groups; as well as efforts to enhance the protection of civilians in armed conflict, including women and children. The General Assembly, in its resolution 65/283 on strengthening the role of mediation in the peaceful settlement of disputes, conflict prevention and resolution, also noted that hostage-taking still persisted in many parts of the world.

10. The International Convention for the Protection of All Persons from Enforced Disappearance, referenced in resolution 54/3 of the Commission on the Status of Women, entered into force on 23 December 2010. As of October 2011, 90 States had signed the Convention, and 30 had ratified or acceded to it. The establishment of the Committee on Enforced Disappearances marks an important milestone in respect of the protection of persons from enforced disappearances. All States parties are obliged to submit regular reports to the Committee on how those rights are being implemented. The Committee met for the first time in November 2011. The Secretary-General submitted a report on the status of the Convention (A/66/284) to the General Assembly at its sixty-sixth session. In addition, the first observance of the International Day of the Victims of Enforced Disappearances, established by the General Assembly pursuant to its resolution 65/209, was held on 30 August 2011.

11. The fate of missing persons is another issue linked to the subject of the present report that has been discussed in intergovernmental processes since the previous report. The Human Rights Council, in follow-up to its resolution 7/28 on missing persons, which, inter alia, requests States to pay the utmost attention to cases of children and women reported missing in connection with armed conflicts and to take appropriate measures to search for and identify those children and women, has continued to call for and receive information on this topic. The issue of missing persons has also been addressed by the General Assembly. In its resolution 65/210 on missing persons, the Assembly requested the Secretary-General to submit to the Human Rights Council at its relevant session and to the General Assembly at its sixty-seventh session a comprehensive report on the implementation of resolution 65/210, including relevant recommendations.

12. In March 2011, at the request of the Human Rights Council, the Office of the United Nations High Commissioner for Human Rights organized a panel discussion on the issue of human rights in the context of action taken to address terrorist hostage-taking (see A/HCR/18/29). Panellists raised concerns about the increasing phenomenon of hostage-taking and emphasized the need to take all measures considered appropriate to ease the situation of hostages and facilitate their release. In 2011, hostage-taking linked to maritime piracy was addressed by both the General Assembly and the Security Council.

13. Special rapporteurs, within their respective mandates, and the Special Representative of the Secretary-General for Children and Armed Conflict have continued to address issues related to the subject of the present report in their reporting in line with the invitation in resolution 54/3 of the Commission on the Status of Women. For example, in her report of 3 August 2011 (A/66/256), the Special Representative of the Secretary-General for Children and Armed Conflict provided details on progress made over the past year, including on awareness-raising, partnership building, information collection and the release of children from armed forces and groups. Information on the release of children from armed forces and groups has also been provided in country-specific reports on children and armed conflict[1] and in the report of the Secretary-General on children and armed conflict (A/65/820-S/2011/250). The latter report noted a growing trend in the detention of children on the grounds of association with armed groups, including threats of violence against or ill-treatment of children for purposes of intelligence-gathering. Concerns linked to violence against women in custody, including sexual violence, have been raised by both the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment and the Special Rapporteur on violence against women, its causes and consequences (see, for example, A/66/215).

14. The Secretary-General and United Nations entities have, as requested by the Commission in its resolution 54/3, continued to make widely available information and materials related to Security Council resolution 1325 (2000) on women and peace and security and its related resolutions 1820 (2008), 1888 (2009), 1889 (2009) and 1960 (2010). Reports and briefings on progress in the implementation of these resolutions are provided to the Security Council on a regular basis. Reviews have shown that progress in implementation of those resolutions has been uneven. While many national frameworks for protection have been strengthened, serious concerns related to the protection of women and girls in armed conflict remain.

IV. Observations and recommendations

15. **The contributions from Member States to the present report demonstrate their commitment to the strengthening of legal, policy and other frameworks and mechanisms for the protection of women and children. However, the number of responses received from Member States provides only a limited indication of the implementation of resolution 54/3 of the Commission on the Status of Women on the release of women and children taken hostage, including those subsequently imprisoned, in armed conflicts.**

[1] See, for example: S/2010/36, S/2010/183, S/2010/369, S/2010/577, S/2011/55, S/2011/64, S/2011/241, S/2011/366 and S/2011/413.

16. **At the same time, it is worth noting, as illustrated by the information available, that several new, as well as existing, processes are in place to address and take more determined action on issues such as enforced disappearance, missing persons, hostage-taking and the protection of women and children in armed conflicts. Since the previous report of the Secretary-General, attention has been given to issues relevant to the topic covered in resolution 54/3 in a number of intergovernmental bodies, including the General Assembly, the Security Council and the Human Rights Council. Opportunities could therefore be sought to further expand attention in those processes to prevent and combat acts of hostage-taking and to determine the identity, fate and whereabouts of women and children taken hostage and facilitate their immediate release. The Commission on the Status of Women may thus consider ways to streamline inputs on this topic as part of established contributions to such intergovernmental and expert bodies.**

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Ending female genital mutilation

Report of the Secretary-General

Summary

Pursuant to resolution 54/7 of the Commission on the Status of Women, the present report provides information on measures taken by Member States and activities carried out within the United Nations system to address female genital mutilation. The report concludes with recommendations for future action.

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I. Introduction

1. In its resolution 54/7 (E/2010/27-E/CN.6/2010/11) on ending female genital mutilation, the Commission on the Status of Women urged States to, inter alia, enact and enforce legislation to prohibit female genital mutilation, develop social and psychological support services and care, and take measures to improve health, in order to assist women and girls who are subjected to this type of violence. The resolution also called on States to develop, support and implement comprehensive and integrated strategies for the prevention of female genital mutilation; develop policies to ensure effective implementation of national legislative frameworks on eliminating discrimination and violence against women and girls, in particular female genital mutilation; and develop unified methods and standards for the collection of data on all forms of discrimination and violence against women and girls, including on female genital mutilation. The Commission requested the Secretary-General to submit to it at its fifty-sixth session, in 2012, a report on the implementation of the resolution. The present report, submitted in accordance with that request, is based, inter alia, on information received from Member States[1] and entities of the United Nations system,[2] as well as on contributions by Member States to the Secretary-General's database on violence against women.[3] It covers the period since the previous report to the Commission (E/CN.6/2010/6), up to 31 October 2011.[4]

II. Background

2. According to the World Health Organization (WHO),[5] there are an estimated 130 million to 140 million girls and women in the world who have undergone female genital mutilation. Every year, approximately 3 million girls and women are at risk of being subjected to such mutilation. The practice is prevalent in 28 countries in Africa and in some countries in Asia and the Middle East. In addition, a

[1] Replies were received from Austria, Belgium, Burkina Faso, Cameroon, Denmark, the Dominican Republic, Finland, Italy, Japan, Mexico, the Philippines, Portugal, Sweden, Switzerland and the United Kingdom of Great Britain and Northern Ireland. The contribution of Qatar received after the deadline for the previous report (E/CN.6/2010/6) is also considered in the present report.

[2] The Joint United Nations Programme on HIV/AIDS, the Department of Public Information, the United Nations Children's Fund (UNICEF), the United Nations Development Programme, the United Nations Educational, Scientific and Cultural Organization, the United Nations Entity for Gender Equality and the Empowerment of Women, the Office of the United Nations High Commissioner for Refugees, the Permanent Forum on Indigenous Issues, the secretariat for the Convention on the Rights of Persons with Disabilities, the United Nations Population Fund (UNFPA) and the World Health Organization (WHO).

[3] Contributions to the Secretary-General's database by the following States were used for the report: Côte d'Ivoire, Djibouti, Germany, Liberia, Norway, the Sudan and Yemen.

[4] This report uses the term "female genital mutilation" in accordance with resolution 54/7 of the Commission on the Status of Women. Some United Nations agencies use the term "female genital mutilation/cutting", wherein the additional term "cutting" is intended to reflect the importance of using non-judgemental terminology in the context of practising communities. Both terms emphasize the fact that the practice is a violation of girls' and women's human rights.

[5] WHO, "An update on WHO's work on female genital mutilation (FGM): Progress report" (2011).

growing number of women and girls among immigrant communities have been subjected to or are at risk of female genital mutilation in Australia and New Zealand, as well as in countries in Europe and North America.[5]

3. According to the Department of Economic and Social Affairs,[6] female genital mutilation continues to be widespread but appears to be declining slightly. Numerous efforts at the national, regional and international levels involving a wide range of actors have contributed to the decline. Initiatives such as enactment of laws prohibiting female genital mutilation, complemented by comprehensive policies and prevention measures, including community-based programming, have created changes in social beliefs and behaviour that have led to the abandonment of female genital mutilation.[7] For example, 15 African States where female genital mutilation is prevalent and a number of States in other parts of the world have enacted laws criminalizing the practice (A/61/122/Add.1 and Corr.1).

4. Nonetheless, some trends on female genital mutilation indicate that the average age at which girls are subjected to the practice is becoming lower in some countries and that, increasingly, medical professionals are involved[5] A recent analysis of existing data shows that over 18 per cent of all girls and women who have been subjected to female genital mutilation have had the procedure performed by a health-care provider.[8] Adverse cultural norms, practices and traditions, as well as patriarchal attitudes and deep-rooted stereotypes regarding the roles, responsibilities and identities of women and men, that perpetuate discrimination against women and girls, are some of the underlying factors that contribute to the continuation of the practice (see, for example, A/63/38).

III. Global and regional legal and policy developments

5. During the reporting period, United Nations bodies continued to address female genital mutilation as a human rights violation with detrimental effects on the health of women and girls. The General Assembly, in its resolution 65/228 on strengthening crime prevention and criminal justice responses to violence against women, urged States to review, evaluate and update their criminal laws in order to ensure that harmful traditional practices, including female genital mutilation, in all their forms, are criminalized as serious offences under the law. In its resolution 64/145 on the girl child, the Assembly urged States to enact and enforce legislation to protect girls from female genital mutilation; to complement punitive measures with educational activities designed to promote a process of consensus towards the abandonment of female genital mutilation; and to provide appropriate services for those affected by the practice.

6. The Commission on the Status of Women adopted resolution 54/7 on ending female genital mutilation at its fifty-fourth session, in 2010, in which it recognized that female genital mutilation violates and impairs or nullifies the enjoyment of the

[6] See Department of Economic and Social Affairs, *The World's Women 2010: Trends and Statistics*, 2010.

[7] See UNICEF, *Legislative Reform to Support the Abandonment of Female Genital Mutilation/Cutting, 2010*, and *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change — Annual Report 2010*.

[8] See *Global Strategy to Stop Health-care Providers from Performing Female Genital Mutilation, 2010*, available from http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.9_eng.pdf.

human rights of women and girls and constitutes a serious threat to the health of women and girls. In the same resolution, the Commission called upon States to strengthen advocacy and awareness-raising programmes and to develop policies, protocols and rules towards the elimination of such practices. In addition, the Commission adopted resolutions 54/2 and 55/2, both on women, the girl child and HIV and AIDS, at its fifty-fourth and fifty-fifth sessions. In those resolutions, the Commission expressed its concern that the vulnerability of women and girls to HIV is increased by, inter alia, female genital mutilation, and it urged Governments to strengthen and implement legal, policy, administrative and other measures for the prevention and elimination of all forms of violence against women and girls, including female genital mutilation.

7. The Permanent Forum on Indigenous Issues also addressed violence against women and female genital mutilation, stressing the importance of adopting an intercultural approach in the prevention and eradication of violence against women (see E/2010/43-E/C.19/2010/15, para. 163), and recommending that States should ensure that all cultural and customary practices that negatively affect the rights of indigenous women (for example, female genital mutilation), are eliminated, including through legislation (see E/2006/43-E/C.19/2006/11, para. 53).

8. The Human Rights Council adopted resolution 14/12 on accelerating efforts to eliminate all forms of violence against women and ensuring due diligence in prevention, in which it urged States to publicly condemn violence against women and provide visible and sustained leadership at the highest levels to prevent all forms of violence against women and girls, and, in particular, in efforts to confront the attitudes, customs, practices and gender stereotypes that lie at the core of discriminatory and harmful acts and practices that are violent towards women, such as female genital mutilation. The Council also adopted resolution 13/20 on the rights of the child, which addressed sexual violence against children and strongly condemned all forms of sexual violence and abuse against children, including female genital mutilation. The Working Group on the Universal Periodic Review of the Council issued several recommendations on ending female genital mutilation to countries under review. The Working Group recommended that Governments prohibit female genital mutilation (see A/HRC/16/17, recommendation No. 25), ensure that existing laws prohibiting female genital mutilation are enforced throughout the countries concerned (see A/HRC/18/16, recommendation No. 107), and take all measures to ensure the prohibition of female genital mutilation through awareness-raising and sensitization activities (see A/HRC/17/15, recommendation No. 26).

9. The Committee on the Rights of the Child, in its general comment No. 13 (CRC/C/GC/13) on the right of the child to freedom from all forms of violence, outlined harmful practices, including female genital mutilation, among the forms of violence that children can experience. The Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women are in the process of elaborating a joint general recommendation/comment on harmful practices, including female genital mutilation.

10. Special Rapporteurs of the Human Rights Council devoted attention to and made recommendations on the elimination of female genital mutilation. The Special Rapporteur on violence against women, its causes and consequences and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or

punishment have continuously addressed the issue (see, for example, A/HRC/17/26/Add.1 and A/HRC/13/39/Add.4, respectively), including in their dialogue with Governments and in the context of country visits. In his 2010 report (A/HRC/13/39), the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment stated that, by not acting with due diligence to protect victims of female genital mutilation, States may commit torture or cruel, inhuman or degrading treatment or punishment by acquiescence. In his 2010 interim report (see A/65/207), the Special Rapporteur on freedom of religion and belief stated that States should penalize those performing female genital mutilation and develop prevention measures, including through dialogues between Government authorities and religious leaders and other members of society. Female genital mutilation has also been the subject of a number of individual complaints and urgent appeals sent to United Nations Special Rapporteurs.

11. The importance of enhancing efforts at the global level to address the practice of female genital mutilation was reaffirmed by the decision of the Assembly of the African Union on the support of a draft resolution at the sixty-sixth session of the General Assembly to ban female genital mutilation in the world (see Assembly/AU/Dec.383 (XVII)), adopted at the seventeenth session of the Assembly of the African Union . In that decision, the Assembly of the African Union called upon the United Nations General Assembly to adopt a resolution at its sixty-sixth session to ban female genital mutilation worldwide, by harmonizing the actions of its Member States and by providing recommendations and guidelines for the development and strengthening of regional and international legal instruments and national legislations. Following the African Union decision, a representative of Burkina Faso brought the issue of female genital mutilation to the attention of the Third Committee of the General Assembly, and announced the intention of the African Group to introduce a resolution at its sixty-sixth session on ending female genital mutilation.

IV. Measures reported by Member States and United Nations entities

12. Member States and United Nations entities have worked towards ending female genital mutilation by implementing international human rights conventions through national legal frameworks, policies, programmes and institutional mechanisms for the prevention of the practice and support to victims, data collection and collaboration among different stakeholders at the national, bilateral, regional and international levels.

A. International instruments[9] and national legislation

13. All of the reporting Member States are party to the Convention on the Elimination of All Forms of Discrimination against Women and to the Convention on the Rights of the Child, the two international treaties referred to in paragraph 1 of resolution 54/7 of the Commission. In accordance with this international framework,

[9] Information in this section is taken from Government submissions and the multilateral treaties website of the Office of Legal Affairs.

States parties are required to enact laws and policies to address female genital mutilation. Reference was also made by some Member States to their adherence to regional legal instruments that contain provisions on the elimination of female genital mutilation, including the African Charter on the Rights and Welfare of the Child, which entered into force in 1999, and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which entered into force in 2005.[10] Some reporting States are signatories to the Council of Europe Convention on preventing and combating violence against women and domestic violence (CETS No.210), a legally binding instrument that was adopted by the Committee of Ministers of the Council of Europe on 7 April 2011 and includes provisions on female genital mutilation.

14. A comprehensive legal framework that prohibits female genital mutilation and provides prevention measures and support for victims and women at risk is crucial. In Italy for example, a comprehensive law was adopted, which not only prohibits female genital mutilation but also mandates a range of prevention measures and support services to victims of female genital mutilation. A number of States have either criminalized female genital mutilation (Belgium, Burkina Faso, Denmark, Finland, Italy, Portugal, Sweden, Switzerland and the United Kingdom of Great Britain and Northern Ireland) or ruled that tradition cannot be invoked as a ground of defence (Portugal). In Kenya, the Prohibition of Female Genital Mutilation Bill was adopted in 2010, with the support of the United Nations Children's Fund (UNICEF)-United Nations Population Fund (UNFPA) Joint Programme on Female Genital Mutilation/Cutting, while in Ethiopia, a draft bill is being debated in Parliament. Some States (Italy and the United Kingdom) have introduced more severe penalties varying from fines to imprisonment. Prison terms range from one to six years and sentences are increased in such aggravating circumstances as cases of female genital mutilation committed against minors, for profit and/or resulting in death (Belgium, Denmark, Finland and Italy). In Burkina Faso, commitment of the crime by medical practitioners is punished by a suspension of their licences. Legislation in numerous States creates extraterritorial jurisdiction, punishing female genital mutilation even if performed in another country where the practice is not prohibited, in the light of the fact that the practice can be committed across borders (Belgium, Denmark, Sweden, Switzerland and the United Kingdom). In order to enhance the enforcement of legislation, newly adopted laws or those being considered for adoption were widely disseminated (Belgium, Burkina Faso and the United Kingdom); and sensitization workshops were conducted in Eritrea with support from the United Nations Development Programme (UNDP) on Proclamation 158/2007 abolishing female genital mutilation/cutting.

15. States have adopted different laws or applied provisions to their existing legislation to further protect and support women and girls subjected to or at risk of female genital mutilation. In Sweden, the Social Services Act requires professionals to report to public administration authorities when there is a reason to believe a girl is at risk of or has already been subjected to female genital mutilation. In some States, it is illegal not to assist a person at risk of female genital mutilation by not reporting the case to the authorities (Belgium and Djibouti). The duty of medical professionals to observe confidentiality is negated in other States, including Belgium, if they encounter cases of female genital mutilation. In Portugal, State

[10] Both treaties are available from www.africa-union.org/root/au/Documents/Treaties/treaties.htm.

intervention in cases of female genital mutilation is provided under the Law on the Protection of the Children. In Burkina Faso, the Civil Code provides that victims of female genital mutilation are entitled to compensation. Some States, including Belgium and Portugal, recognize female genital mutilation for the purposes of asylum laws and procedures.

16. Enforcement of legislation still remains a challenge. While some States, such as the United Kingdom, noted that the law on female genital mutilation has been a successful deterrent of the practice, little information has been reported on the impact of enacted legislation. Human rights treaty bodies, while welcoming the adoption of laws to address female genital mutilation in their concluding observations to States parties, have also expressed concerns about the underreporting of cases of female genital mutilation;[11] the inconsistent enforcement of laws due to insufficient allocation of funds; lack of coordination among the relevant actors; low awareness of existing laws;[12] and impunity of perpetrators. They urged States to create adequate conditions for victims to report incidents of harmful traditional practices;[13] and to ensure the full implementation of legislation prohibiting female genital mutilation, including the prosecution of perpetrators.[14]

17. United Nations entities have supported States to adopt or improve laws that prohibit female genital mutilation and, to that end, have collaborated with national authorities to develop tools and establish mechanisms. Capacity-building of legislators to promote the adoption of laws addressing female genital mutilation was supported by the UNFPA-UNICEF Joint Programme, which is a leading actor in accelerating the abandonment of the practice in 17 African countries, in collaboration with the non-governmental organization No Peace Without Justice; and by the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), which, for instance, strengthened the Kenya Women Parliamentary Association. In 2010, UN-Women published a *Supplement to the Handbook for Legislation on Violence against Women: "Harmful practices" against women*.[15] The handbook was produced on the basis of an expert group meeting on good practices in legislation on "harmful practices" against women (convened by the former Division for the Advancement of Women, in cooperation with the Economic Commission for Africa). Its recommendations relevant to female genital mutilation include that legislation should:

(a) Define female genital mutilation and not distinguish between the different types of female genital mutilation for the purposes of punishment; clearly state that consent cannot be a defence to a charge of female genital mutilation; establish a separate and distinct offence of the act of female genital mutilation; and establish that perpetrators are subject to higher criminal penalties associated with crimes against children;

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[11] See CEDAW/C/DJI/CO/1-3, para. 18 and CRC/C/NOR/CO/4, para. 44.

[12] See CEDAW/C/ETH/CO/6-7, para. 20.

[13] See CAT/C/ETH/CO/1, para. 32; CAT/C/GHA/CO/1, para. 23.

[14] See CEDAW/C/ITA/CO/6, para. 53; CEDAW/C/DJI/CO/1-3, para. 19; CEDAW/C/UGA/CO/7, para. 22; CRC/C/EGY/CO/3-4, para. 69; CEDAW/C/BFA/CO/6, para. 26; CEDAW/C/EGY/CO/7, paras. 41-42, CCPR/C/ETH/CO/1, para. 10; CCPR/C/TGO/CO/4, para. 13; CRC/C/NOR/CO/4, para. 45; CEDAW/C/OMN/CO/1, para. 26.

[15] Available from www.un.org/womenwatch/daw/vaw/handbook/Supplement-to-Handbook-English.pdf.

(b) Mandate that all relevant professionals, including practitioners and employees in day-care centres, child welfare services, health and social services, schools and out-of-school care schemes and religious communities report cases of female genital mutilation to the appropriate authorities;

(c) Where necessary, mandate that specialized shelters be established for victims/survivors of certain "harmful practices", including female genital mutilation;

(d) Acknowledge that communities have an integral role to play in the abandonment of female genital mutilation, and call for governmental support, where requested, for community-based abandonment initiatives; and, where appropriate, support community-based initiatives that are targeted at changing behaviour and attitudes, including alternative rites of passage and the re-training of traditional practitioners for alternative professions, such as midwifery.

B. National action plans, strategies and coordination mechanisms

18. National action plans on eliminating female genital mutilation offer a framework for the development, implementation, monitoring and evaluation of comprehensive and coordinated strategies. National action plans on female genital mutilation and/or national plans of action on violence against women that address female genital mutilation are in place in a number of countries, including Austria, Belgium, Burkina Faso, Cameroon, Djibouti, Italy, Liberia, Norway, the Sudan, Sweden and the United Kingdom. A national plan of action to address female genital mutilation was elaborated in Mali, with UNDP support to the Ministry for the Promotion of Women, while new national policies to address the practice were approved in Guinea-Bissau and Senegal, with support from the UNICEF-UNFPA Joint Programme. Finland is in the process of developing a national action plan to address female genital mutilation. Some of the national action plans include measures to implement laws, prevent female genital mutilation, provide support services, systematize data collection and analysis on the prevalence of female genital mutilation, and promote cooperation among different actors involved in addressing the issue. In Burkina Faso, an evaluation plan was further elaborated to monitor the implementation and evaluation of the national action plan.

19. States also address female genital mutilation in national plans or strategies related to other issues. For example in Côte d'Ivoire, Denmark, Germany, Norway and Portugal, national action plans and strategies on gender equality, women and peace and security, and women's human rights, set out a number of actions to eliminate female genital mutilation.

20. A promising practice in several States consists of involving multiple stakeholders, including non-governmental organizations and representatives of affected groups, in the elaboration, implementation and evaluation processes of national action plans and strategies that address female genital mutilation (Austria, Belgium, Burkina Faso, Norway, Portugal and the United Kingdom).

21. The establishment of wide-ranging institutional mechanisms to coordinate the implementation of national action plans and policies has proven to be a good practice, given the multiplicity of responses required. To that end, dedicated national mechanisms, such as inter-ministerial and multisectoral working groups,

national committees and/or commissions responsible for the coordination and implementation of efforts aimed at the elimination of female genital mutilation, have been established in various States, including Austria, Burkina Faso, Djibouti, Italy, Portugal and Yemen.

22. Limited information was provided on evaluations of the implementation of national action plans, their impact and the allocation of resources for their implementation. While human rights treaty bodies have welcomed the adoption of national action plans, strategies, programmes and legislation to address female genital mutilation, they have also expressed concerns that female genital mutilation is still widely practised; and have urged States to better coordinate anti-female-genital-mutilation activities (see CRC/C/BFA/CO/3-4, para. 59) and to ensure the comprehensive implementation of national action plans.[16]

23. United Nations entities have assisted States in developing policies to effectively address female genital mutilation and its effects on the health of women and girls. Efforts increased in 2010-2011 through support from the UNICEF-UNFPA Joint Programme to better integrate the health implications of female genital mutilation into national reproductive health strategies. In *UNAIDS Strategy 2011-2015: Getting to Zero*, the Joint United Nations Programme on HIV/AIDS (UNAIDS) calls for countries to make their response to violence against women an integral part of HIV/AIDS programmes and strategies in order to stop harmful practices.

C. Prevention measures and support for victims and women at risk

24. Prevention is a core component of any strategy to end female genital mutilation and it needs to complement legislation and other measures in order to effectively eliminate the practice. States have emphasized the importance of prevention and the transformation of social beliefs and behaviours towards the abandonment of female genital mutilation, through community-based initiatives and partnerships at all levels, including with non-governmental organizations (Belgium, Denmark, Finland, Sweden and the United Kingdom).

Awareness-raising and advocacy

25. Initiatives aimed at preventing female genital mutilation through awareness-raising on the issue and its detrimental effects on the psychological and physical health of women and girls; legislation prohibiting the practice; available support services for victims; and the promotion of women's and girls' human rights were carried out in several States, including Austria, Belgium, Burkina Faso, Cameroon, Djibouti, Italy, Portugal, Sweden, Switzerland and the United Kingdom. Such initiatives, often conducted in collaboration with non-governmental organizations, included conferences, seminars and workshops, social mobilization campaigns, including theatre plays, and communication materials such as leaflets and posters translated into several languages and disseminated online. States reported the organization of events to commemorate the International Day of Zero Tolerance to Female Genital Mutilation (on 6 February) and as part of the 16 Days of Activism against Gender Violence campaign, which further promoted awareness of the

[16] CEDAW/C/KEN/CO/7, para. 20; CRC/C/SDN/CO/3-4, para. 14.; CRC/C/CMR/CO/2, para. 60.

practice. Target groups for those initiatives included immigrant communities, professionals dealing with women and girls at risk of female genital mutilation, women who have experienced female genital mutilation, traditional and religious leaders, teachers and students.

26. The media played an important role in the decline of the practice. In the Gambia, media campaigns and ongoing radio programmes promoting the abandonment of female genital mutilation were produced, with support from the UNFPA-UNICEF Joint Programme. The importance of building alliances was recognized in Burkina Faso, where different networks of religious and traditional leaders, journalists and non-governmental organizations were created to further advocate for the abandonment of female genital mutilation. Condemnation of the practice by high-profile figures who exert influence on public opinion can further contribute to the prevention of female genital mutilation. In Burkina Faso, for example, the First Lady and religious and traditional leaders all condemned the practice.

27. In the context of the campaign of the Secretary General entitled "UNiTE to End Violence against Women", United Nations entities, including the Department of Public Information, UNAIDS, UNESCO, UNFPA, the Office of the United Nations High Commissioner for Refugees (UNHCR), UNICEF, UN-Women and WHO, were further engaged in or supported a wide range of awareness-raising and advocacy initiatives at the global or regional level, mainly in Africa, using a variety of communication channels such as social networks, radio, films, websites, public performances and workshops. A number of entities have further strengthened awareness of the practice by supporting and being engaged in events held to commemorate International Day of Zero Tolerance to Female Genital Mutilation and International Women's Day (UNESCO, UNFPA-UNICEF Joint Programme). UNAIDS, in collaboration with the Government of Uganda, the non-governmental organization REACH and Makerere University and with support from other United Nations entities, continued to support community mobilization in three Sabiny districts to further protect and promote the rights of girls against female genital mutilation. To that end, sensitization workshops among Sabiny people resulted in the abandonment of the practice by traditional practitioners. UNHCR conducted awareness-raising activities on female genital mutilation in refugee camps in Djibouti and Kenya in collaboration with the non-governmental organization CARE.

Community-based programming

28. The importance has been increasingly acknowledged of community-based initiatives, which facilitate a process of social change towards the abandonment of female genital mutilation. In Burkina Faso, development projects that improved overall hygiene and health conditions and supported income-generating activities and community mobilization, have resulted in public declarations of abandonment of female genital mutilation in 95 communities of the country. In another initiative in Burkina Faso, community patrols by the military police were used to sensitize communities to the harmful effects of female genital mutilation with a view to discouraging the practice. In the United Kingdom, the Scottish government supported community engagement in prevention activities and the development of a minority ethnic women's network to work with policymakers on issues related to female genital mutilation.

29. The need to address female genital mutilation as a social norm and to empower communities to achieve sustained social change towards the abandonment of female genital mutilation guided several community-based initiatives supported by United Nations entities. For instance, the UNFPA-UNICEF Joint Programme supported the building of partnerships among multiple stakeholders and community education on reproductive health, HIV/AIDS and human rights in 12 countries, thereby facilitating community dialogues on female genital mutilation. Those efforts resulted in collective public declarations by community and religious leaders on commitment to end the practice in Burkina Faso, Djibouti, Ethiopia, the Gambia, Guinea, Kenya, Somalia and the Sudan. The non-governmental organization Tostan, in collaboration with the UNFPA-UNICEF Joint Programme, carried out community empowerment programmes in several sub-Saharan countries, using human rights education and community ownership approaches towards the abandonment of the practice. The UN-Women-administered United Nations Trust Fund to End Violence against Women supported the non-governmental organization Save the Children Sweden to conduct human rights-based community mobilization in the Gambia, Guinea, Mali and Senegal that engaged traditional leaders, youth, police officers and health workers.

Educational programmes

30. Educational curricula and institutions provide an important forum for educating on and raising awareness of female genital mutilation. In Burkina Faso, specific modules on female genital mutilation were included in the curricula of primary and secondary schools. In order to enrol youth advocates, in particular boys, for ending female genital mutilation, the United Nations Trust Fund to End Violence against Women supported non-governmental organizations such as Save the Children Sweden to integrate awareness-raising programmes in school curricula, in collaboration with the Ministries of Education of the Gambia, Guinea, Mali and Senegal; and such as Action Aid Ethiopia to establish boys' clubs in primary and secondary schools to raise awareness on harmful practices among students.

31. Teacher training on female genital mutilation was organized in several States (Austria, Burkina Faso and Italy). Teacher training on female genital mutilation, HIV/AIDS, human rights and reproductive rights was also carried out in Brazil, Cape Verde, Guinea-Bissau and Senegal, with support from UNESCO.

Training

32. Training programmes for professionals dealing with cases of women and girls at risk of or who have already undergone female genital mutilation can enhance the implementation of laws and policies addressing the practice. Such training took place in several States, targeting health professionals, social workers, traditional practitioners, law enforcement and immigration officials (Austria, Belgium, Burkina Faso, Cameroon, Finland, Sweden, Switzerland and the United Kingdom). Training of health-care providers, including traditional birth attendants, and of law enforcement officials was also carried out in Djibouti, Ethiopia, the Gambia, Guinea-Bissau, Kenya and the Sudan, with support from the UNICEF-UNFPA Joint Programme. Training programmes focused on women's human rights, health issues related to female genital mutilation, investigation techniques and the implementation of legal and policy frameworks. Guidelines, training modules and good-practice handbooks were also produced to further assist relevant professionals

in the prevention and management of cases of female genital mutilation. WHO published online information for health-care providers and researchers, including counselling guidelines for victims. In order to address the increased medicalization of the practice, the UNFPA-UNICEF Joint Programme supported the publication of a training manual for health-care providers in Kenya.

33. Training on issues related to harmful practices, the detrimental effects of female genital mutilation and women's human rights was provided for other stakeholders in order to strengthen their role in preventing the practice. Such training was offered to religious and traditional leaders as well as journalists in Burkina Faso. In Ethiopia, the United Nations Trust Fund to End Violence against Women supported the non-governmental organization Action Aid to train traditional and religious leaders in order to further engage them in community mobilization. In order to strengthen media coverage of the issue of female genital mutilation and to encourage community dialogues about the practice, the UNICEF-UNFPA Joint Programme supported capacity-building of journalists and media institutions in Ethiopia, the Gambia, Guinea-Bissau, Kenya, the Sudan and the United Republic of Tanzania, in collaboration with the Association for Women in Development. The Joint Programme also supported the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children to train youth leaders from Ethiopia, Kenya, Uganda and the United Republic of Tanzania and increase their capacity as peer educators and advocates.

34. While some Member States reported on the allocation of resources to implement prevention activities (Italy and Switzerland), additional information on how systematically those programmes were carried out and evaluated has been limited. Human rights treaty bodies have expressed concerns about States not having sufficiently sustained actions to modify or eliminate stereotypes, negative cultural values and harmful practices (see CEDAW/C/ETH/CO/6-7, para. 18). The bodies have urged States to continue and increase their awareness-raising and educational efforts to completely eliminate female genital mutilation;[17] to ensure that such measures are systematically and consistently mainstreamed, targeting all segments of society (see CRC/C/CMR/CO/2, para. 60); and to assess the impact of such measures (see CEDAW/C/ZAF/CO/4, para. 21).

Support for victims and women at risk

35. A number of Member States have reported on measures to protect and assist women and girls who have experienced or are at risk of female genital mutilation (Belgium, Burkina Faso, Cameroon, Italy, Portugal, Sweden, Switzerland and the United Kingdom). For example, specialized clinics to treat victims have been created in Sweden and the United Kingdom. In Burkina Faso, medical kits are distributed to victims in order to mitigate the health effects of the practice. Hotlines have been established in a few States to receive reports on cases of female genital mutilation and provide information on available support services (Burkina Faso and Italy). In Switzerland, in addition to medical treatment, women and girls who have experienced female genital mutilation are offered literacy courses to further empower them. Legal aid is provided to victims of the practice by the National Association of Women Lawyers, with support from UN-Women, in States such as

[17] CEDAW/C/KEN/CO/7, para. 18; CEDAW/C/EGY/CO/7, para. 42; CEDAW/C/BFA/CO/6, para. 24; CEDAW/C/UGA/CO/7, para. 22.

Burkina Faso, Côte d'Ivoire, Guinea, Mali, the Niger and Sierra Leone. Some countries, including Belgium, Portugal and Sweden, have granted asylum to women and girls at risk of female genital mutilation.

36. United Nations entities have stressed the negative effects of female genital mutilation on the health of women and girls, including disability, and focused efforts on ensuring that victims and girls at risk have access to related services and support. For example, UNHCR supported the provision of counselling services and medical assistance to women who experienced female genital mutilation in refugee camps. In order to address the medicalization of the practice, the UNFPA-UNICEF Joint Programme supported the creation of an anonymous reporting mechanism in Egypt, to receive information on doctors who continue to perform the practice despite its prohibition by law. A "Global strategy to stop health-care providers from performing female genital mutilation" was published in 2010 by WHO, in collaboration with seven other United Nations entities and six professional organizations. The strategy outlines recommendations to address the medicalization of the practice, including the creation of legislative and regulatory frameworks, their monitoring and evaluation, and the allocation of funds for their implementation.

D. Data collection and research

37. The availability of better data is critical for there to be evidence-based legal and policy development to address the elimination of female genital mutilation. A number of States reported that they had no available data on female genital mutilation (Belgium, Finland, the Philippines, Sweden and Switzerland) or that no cases had been reported (the Dominican Republic and Mexico). Qatar reported that the practice does not exist in the country. Burkina Faso provided data on the prevalence of female genital mutilation, the number of arrests and prosecuted cases, and reported on the training of officials tasked with the collection and analysis of such data. The national centre of information and documentation on women and children in Mali, in collaboration with UNDP and with support from Germany, has started to collect data on female genital mutilation. Lack of data was reported as an impediment for the evaluation of actions taken to address female genital mutilation (Belgium and Cameroon). Human rights treaty bodies, while noting a decline of female genital mutilation in urban areas, expressed concerns about the prevalence of the practice in rural areas (see CEDAW/C/ETH/CO/6-7, para. 20) and in various countries under review;[18] they deplored the lack of statistical data on prevalence and urged States to collect statistics and other data on the practice and to include data collection and analysis of traditional harmful practices in national surveys.[19]

38. Surveys and studies were carried out in States to enhance knowledge of the prevalence of female genital mutilation (Belgium, Cameroon and Italy). A situation analysis of female genital mutilation was carried out in Cameroon, which found that the practice was prevalent in Yaoundé and in the north and south-west regions. In Belgium, a study was carried out by the Institute of Tropical Medicine, revealing that out of 22,840 women residing in Belgium who originally came from countries

[18] CRC/C/SDN/CO/3-4, para. 56; CEDAW/C/DJI/CO/1-3, para. 18; CEDAW/C/UGA/CO/7, para. 21.

[19] CEDAW/C/OMN/CO/1, para. 26; CRC/C/CMR/CO/2, para. 60.

where female genital mutilation is practised, 8,235 had probably experienced or were at risk of female genital mutilation.

39. United Nations entities have supported the increased availability of data and knowledge regarding female genital mutilation. The 2010 multi-country UNICEF study entitled *The Dynamics of Social Change-Towards the abandonment of female genital mutilation/cutting in five African countries* found that programmes that apply a holistic approach and address female genital mutilation as a social norm are more effective. UNICEF is in the process of finalizing another study entitled *Female Genital Mutilation/Cutting: A statistical exploration*, which reviews data from all surveys carried out by UNICEF and explores the variation on prevalence from country to country depending on the impact of different socio-economic and demographic factors. UNESCO prepared a framework for collecting qualitative and quantitative information on women's empowerment, which includes a set of indicators on female genital mutilation. The organization also produced reports containing studies on how female genital mutilation affects girls' access to education and on the linkages between female genital mutilation, culture and development. WHO has disseminated information on good practices for the abandonment of female genital mutilation and is currently engaged in research on sociocultural factors contributing to the abandonment or continuation of the practice. WHO also carried out research on the health consequences of the practice and their treatment in Norway.

40. An international conference on female genital mutilation/cutting was held in Nairobi in October 2011, in collaboration with WHO, UNFPA, the International Centre for Reproductive Health and universities from Australia, Belgium, Kenya and the United States of America. The conference attracted participants from Governments, non-governmental organizations, the United Nations and academia with a view to identifying knowledge gaps about health issues related to female genital mutilation and analysing different interventions aimed at ending the practice, including community-based interventions.

E. Bilateral, regional and international cooperation

41. Many States have cooperated in and/or supported bilateral and/or multilateral programmes and projects for the elimination of female genital mutilation, together with United Nations entities, regional bodies and non-governmental organizations (Belgium, Denmark, Djibouti, Finland, Italy, Japan, Portugal, the Sudan, Sweden, Switzerland, the United Kingdom and Yemen). The initiatives often focus on legal reform, prevention efforts, including awareness-raising and training, assistance to and protection of women and girls at risk, the exchange of information on good practices and studies on the prevalence of the practice. Some partnerships and projects also focused on reproductive health and rights (Belgium and Denmark). Burkina Faso, supported by UN-Women and the UNFPA-UNICEF Joint Programme, partnered with Mali to strengthen their efforts to address female genital mutilation being practised across the border between the two countries.

42. Some States have reported that their national development agencies support, either directly or through non-governmental organizations, national efforts to address female genital mutilation in the context of (a) development cooperation initiatives, focusing on various aspects of the practice, such as health risks (the

United Kingdom); and (b) promotion initiatives, such as capacity-building, educational programmes, awareness-raising and community-based programming aimed at changing collective attitudes towards female genital mutilation (Japan and Sweden).

43. Some States, including Burkina Faso, Djibouti, Italy and Portugal, have strengthened regional cooperation and/or been represented at meetings and international seminars aimed at sharing good practices, information on prevalence and trends and work priorities. Burkina Faso for example hosted a subregional conference of First Ladies of West Africa in October 2008, with support from UN-Women, which aimed at engaging leadership at the highest level, sharing good practices and developing common strategies to address female genital mutilation being practised across the borders of Burkina Faso, Côte d'Ivoire, Ghana, Mali and the Niger. The African Union, with support from UN-Women, organized a pan-African conference on "Celebrating courage and overcoming harmful traditions", held in Addis Ababa from 5 to 7 October 2011, aimed at enhancing partnerships and promoting good practices to combat harmful traditional practices, including female genital mutilation. The conference led to the adoption of a framework for action and recommendations on harmful practices, proposing, inter alia, holistic and integrated strategies; cooperation; the improvement of legislative and policy frameworks; prevention measures, including advocacy, awareness-raising and women's empowerment; research on issues related to harmful traditional practices; and monitoring and evaluation of related actions.

44. A number of reporting States, including Italy, Sweden, Switzerland and the United Kingdom, are part of the donor working group on female genital mutilation. The group developed a platform for action towards the abandonment of female genital mutilation/cutting, in which it proposed a common holistic programmatic approach to effectively scale up abandonment efforts, such as the review of national laws and policies, the involvement of a wide range of actors, community empowerment activities to create social change and the provision of support services to victims of female genital mutilation.

V. Conclusions and recommendations

45. **Many actions have been taken at the national, regional and international levels to end female genital mutilation. Efforts have been made to strengthen national legal and policy frameworks, enhance prevention and protection measures, improve knowledge about the practice and how to effectively address it, and facilitate coordination and cooperation at all levels. Female genital mutilation is prohibited by criminal law in many States. States are increasingly complementing such legislation and policies with prevention and protection measures, including information and awareness-raising campaigns, community-based initiatives, educational programmes and training of law enforcement officials, health-care professionals and other stakeholders such as community leaders and journalists, as well as providing medical treatment and support to women and girls who have experienced female genital mutilation. Promising initiatives have included organizing human rights-based prevention initiatives, reaching out to communities as a whole, building partnerships and involving multiple stakeholders at different phases of the programmes.**

46. **Despite the increase in efforts and focus on the abandonment of female genital mutilation, the prevalence of the practice remains a cause for concern. The challenges that have been identified include insufficient enforcement of legislation and policies; limited resources allocated for their implementation; insufficient monitoring and evaluation of the impact of laws, policies and programmes; and lack of data to facilitate monitoring of progress.**

47. **A comprehensive, coordinated, systematic approach based on human rights and gender equality principles and the involvement of multiple stakeholders at all levels, including international and regional bodies, is required to achieve and sustain abandonment worldwide. Strong political commitment is required at the national level, demonstrated by comprehensive national laws and policies and the allocation of sufficient resources, including budgets, for their implementation. Initiatives aimed at the abandonment of the practice should also approach female genital mutilation as a social norm, with a view to initiating processes that foster social dialogues, community empowerment and ownership and result in a sustained collective change of beliefs and behaviour.**

48. **States should continue to ratify international instruments and implement them through national legal and policy frameworks. In accordance with international human rights standards, comprehensive legislation should be adopted that prohibits all forms of female genital mutilation and punishes the perpetrators. Legislation should also mandate a full range of prevention and protection measures for women and girls who have been subjected to or are at risk of female genital mutilation. Provisions for the effective implementation of laws, including budgetary allocations, and mechanisms to coordinate, monitor and evaluate law enforcement should be included in legislation. Laws need to provide for effective sanctions, including for medical professionals performing the practice, or in cases where female genital mutilation is performed in a country where it is not prohibited. The enforcement of legislation needs to be enhanced, including through its wide dissemination and the training of law enforcement officials. Conditions permitting women and girls to report cases of female genital mutilation have to be improved.**

49. **States should ensure that national action plans and strategies on the elimination of female genital mutilation are comprehensive, including a range of prevention and protection measures, and multidisciplinary in scope. They should incorporate clear targets and indicators, provide for ongoing monitoring and impact assessment and ensure coordination among all stakeholders. States should promote the participation of a wide range of stakeholders in the elaboration, implementation, monitoring and evaluation of action plans and strategies. Such stakeholders should include affected groups, practising communities, non-governmental organizations and women's groups. Coordination mechanisms should continue to be strengthened. States should ensure that sufficient resources are allocated for the implementation of all plans and strategies aimed at eliminating female genital mutilation.**

50. **A stronger focus needs to be placed on primary prevention efforts and support to abandonment efforts within existing laws, policies and programmes. Information and awareness-raising campaigns and programmes need to be systematic in reaching the general public, relevant professionals, families and**

communities. Educational programmes focusing on gender equality should be systematically pursued. All segments of society, including women and girls, men and boys, youth, community and faith organizations/leaders and the media should be actively engaged in prevention initiatives. The integral role of communities in the abandonment of female genital mutilation should be recognized and community-based abandonment initiatives supported. Such issues as women's human rights and gender equality, as well as information on reproductive health, maternal health, violence against women and girls, and female genital mutilation and its impact, should be incorporated into educational curricula, community dialogues and the training of actors who can influence a process of social change towards the sustained abandonment of female genital mutilation.

51. Health practitioners, teachers, social workers and other professionals should be trained to identify and handle cases of women and girls who have experienced or are at risk of female genital mutilation. Health professionals should also be trained to appropriately manage the health implications of the practice and specifically to reduce its impact on the reproductive health of women and girls who have been subjected to female genital mutilation. States should promote the adoption and dissemination of standards and guidelines, including by the appropriate professional bodies, that condemn all forms of female genital mutilation being performed or supported by medical practitioners. Training should be provided to other actors who could influence a process of social change towards the abandonment of female genital mutilation, such as religious/traditional leaders and journalists. States should support community-led initiatives aimed at re-training traditional practitioners of female genital mutilation in alternative income-generating activities, where it is identified by communities as necessary, complemented by awareness-raising to limit the demand for the practice.

52. The protection and support of victims of female genital mutilation and women and girls at risk should also be an integral part of legislation, policies and programmes that address the issue. Victims should be provided with a range of specialized services, including legal, psychological, social assistance and health services to ensure their recovery from trauma and the prevention of serious health conditions.

53. Data collection and analysis, including on prevalence, attitudes and beliefs surrounding female genital mutilation as well as on reported cases and enforcement of legislation, should be strengthened and made more systematic, especially with respect to data on younger girls. The sharing of good practices in the prevention and abandonment of female genital mutilation should be reinforced. Qualitative research should also be intensified to improve understanding of sociocultural factors that could facilitate abandonment and inform effective strategies to eliminate female genital mutilation.

54. In all cases, targeted interventions to end female genital mutilation should be addressed in a holistic and comprehensive manner in the context of overall intensified efforts to eliminate all forms of violence and discrimination against women and girls and advance gender equality.

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Actions to strengthen linkages among programmes, initiatives and activities throughout the United Nations system for gender equality, the empowerment of women and girls, protection of all of their human rights and elimination of preventable maternal mortality and morbidity

Report of the Secretary-General

Summary

Pursuant to Commission on the Status of Women resolution 54/5, the present report summarizes actions taken to address maternal mortality, with particular attention to efforts directed towards strengthening linkages among programmes, initiatives and activities throughout the United Nations system for gender equality, the empowerment of women and girls, protection of all their human rights, and elimination of preventable maternal mortality and morbidity. The report, based on contributions from 13 United Nations entities, 18 Member States and academic researchers, finds that, despite strengthening of the normative framework for confronting maternal mortality as a human rights issue having gender inequality and discrimination as root causes, a sustained and coordinated effort to address those factors has yet to emerge.

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I. Background

1. At its fifty-fourth session in 2010, the Commission on the Status of Women adopted resolution 54/5, entitled "Eliminating maternal mortality and morbidity through the empowerment of women" (see E/2010/27 and Corr.1, chap. I.D). In that resolution, the Commission, inter alia, requested the Secretary-General to provide a report to the Commission at its fifty-sixth session in 2012, in consultation with Member States, international organizations and all other relevant stakeholders, taking into account Human Rights Council resolution 11/8 of 17 June 2009 and other relevant United Nations resolutions, on actions to strengthen linkages among programmes, initiatives and activities throughout the United Nations system for gender equality, the empowerment of women and girls, protection of all of their human rights and elimination of preventable maternal mortality and morbidity. The present report responds to that request.

2. The report summarizes initiatives and actions taken by Member States, the United Nations system and civil society organizations to eliminate preventable maternal mortality and morbidity and offers recommendations for further action.

II. Persistence of maternal mortality[1] and morbidity

3. Some 342,000 to 358,000 maternal deaths occurred globally in 2008.[2] The global maternal mortality ratio, or the number of maternal deaths that occur for every 100,000 live births, was 260 in 2008, having declined from 400 in 1990. For developing regions in 2008, the ratio was 290 maternal deaths per 100,000, while in more developed regions, it was only 14 per 100,000.

4. Developing regions varied considerably in maternal mortality levels, with sub-Saharan Africa having the highest maternal mortality ratio, 640 maternal deaths per 100,000 live births, a figure that was well above twice the global average. Among individual countries, four (Afghanistan, Chad, Guinea-Bissau and Somalia) had maternal mortality ratios over 1,000 per 100,000 live births.

5. In terms of trends, the picture is equally mixed (see table). Since 1990, maternal mortality has declined in almost all regions.[3] There have been large declines (greater than 50 per cent) in South Asia, East Asia and the Pacific, and Central and Eastern Europe/Commonwealth of Independent States. Despite a declining trend, the average annual percentage decline in the global maternal mortality ratio of 2.3 per cent per year over the period 1990-2008 falls short of the

[1] The World Health Organization (WHO) defines maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes".

[2] Separate estimates were prepared for 2008 by the United Nations Maternal Mortality Estimation Inter-Agency Group and by the Institute for Health Metrics and Evaluation, University of Washington, Seattle, Washington, United States of America. See Rafael Lozano and others, "Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis", *Lancet*, vol. 378, No. 9797 (24 September 2011), pp. 1139-1165.

[3] The apparent increase in developed regions is insignificant, as the rate has fluctuated around a low level.

figure of 5.5 per cent required to achieve Millennium Development Goal 5, namely, a reduction in the maternal mortality ratio by 75 per cent between 1990 and 2015.

Trends in maternal mortality ratios, 1990-2008

	Estimated maternal mortality ratio[a]						
Region or country group	*1990*	*1995*	*2000*	*2005*	*2008*	*Percentage change between 1990 and 2008*	*Annual percentage change between 1990 and 2008*
Sub-Saharan Africa	870	850	790	710	640	-26	-1.7
Eastern and Southern Africa	750	760	720	630	550	-26	-1.7
West and Central Africa	980	940	870	780	720	-27	-1.7
Middle East and North Africa	270	230	200	180	170	-37	-2.6
South Asia	610	510	430	330	290	-53	-4.2
East Asia and the Pacific	200	160	130	100	88	-56	-4.5
Latin America and the Caribbean	140	130	110	91	85	-41	-2.9
Central and Eastern Europe/ Commonwealth of Independent States	69	60	48	36	34	-52	-4.0
Industrialized countries	12	10	11	14	14	16	0.8
Developing countries	440	410	370	320	290	-34	-2.3
Least developed countries	900	840	750	650	590	-35	-2.4
World	400	370	340	290	260	-34	-2.3

Source: Ann Paxton and Tessa Wardlaw, "Are we making progress in maternal mortality?", *New England Journal of Medicine*, vol. 364, No. 21 (26 May 2011), p. 1991.

[a] Number of maternal deaths per 100,000 live births.

6. The major direct causes of maternal mortality include haemorrhage, infection, high blood pressure, unsafe abortion and obstructed labour. Other important causes include malaria, anaemia and HIV/AIDS.[4] However, the root causes of maternal mortality and morbidity are human rights violations such as discrimination, gender-based violence, including female genital mutilation, and inadequate investment in and/or unequal access to education, basic health, nutrition and basic health care. Health systems are overburdened and constrained by a lack of investment and resources. Competing priorities and insufficient national resources often combine to push women's health out of the political agenda, thereby violating their rights.

7. These factors underlie the wide disparities in maternal mortality that exist across and within countries and regions and that are also evident across residential groups, including rural/urban populations, cultural and religious groups and various social and economic classes. Between wealthy and poor households, for example, wide differentials exist in respect of access to quality care. The widest gaps are in South Asia and sub-Saharan Africa, where the wealthiest women are, respectively, five and three times more likely than the poorest women to be attended by trained health-care workers at delivery. In developing regions as a whole, women in the

[4] See http://www.who.int/topics/maternal_health/en/index.html (accessed 20 December 2011).

richest households are three times as likely as women in the poorest households to receive professional care during childbirth.[5]

8. Several diseases work individually or interactively to predispose pregnant women to higher risks of mortality and morbidity. HIV, malaria and anaemia are particularly dangerous in pregnant women. Although its role is difficult to quantify, it is known that HIV/AIDS contributes to high maternal mortality in many contexts. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), maternal mortality would be 20 per cent lower were it not for HIV.[6] Worldwide, 60,000 pregnant women died in 2009 alone because of HIV.[7] Yet, nearly half of pregnant women living with HIV are not reached by critical services.[8] HIV and AIDS increase the risk of complications such as anaemia, post-partum haemorrhage and puerperal sepsis.[9] The harmfulness associated with gender norms, expectations, stereotypes and roles leaves many women and girls unable to exert control over their sexual and reproductive decision-making, rendering them vulnerable to HIV/AIDS and other sexually transmitted diseases. Pregnant women infected with HIV often have poor access to or inadequate quality of health care because of substantial stigma and discrimination from health-care workers and community members. This is particularly the case for adolescents.[10]

9. Malaria accounts for considerable mortality during pregnancy and often results in severe anaemia. The control of malaria is a major part of the World Health Organization (WHO) "Making Pregnancy Safer" initiative, which recommends intermittent preventive treatment for all pregnant women at risk of *Plasmodium falciparum* infection in sub-Saharan countries with stable malaria transmission.[11] Long-lasting insecticidal nets and indoor residual spraying are the top recommended interventions for reducing malaria transmission. Within households, the use of bednets may be strongly linked to culturally accepted sleeping patterns. Gender plays an important role, as limited supplies of bednets may be reserved for the male head of household.[12] Eliminating malaria infections among pregnant women saves lives of both mothers and infants.

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[5] *The Millennium Development Goals Report 2010* (United Nations United Nations publication, Sales No. E.10.I.7). Available from http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf (accessed 11 December 2011).

[6] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010* (Geneva, 2010).

[7] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015* (Geneva, 2011).

[8] World Health Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Children's Fund (UNICEF), *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2010* (Geneva, WHO, 2010).

[9] James McIntyre, "Mothers infected with HIV: reducing maternal death and disability during pregnancy", *British Medical Bulletin*, vol. 67 (2003), pp. 127-135.

[10] Quarraisha Abdool-Karim and others, "HIV and maternal mortality: turning the tide", *Lancet*, vol. 375, No. 9730 (5 June 2010), pp. 1948-1949.

[11] See http://www.who.int/malaria/world_malaria_report_2011/9789241564403_eng.pdf (accessed 20 December 2011).

[12] See http://www.who.int/gender/documents/gender_health_malaria.pdf (accessed 20 December 2011).

III. Addressing the elimination of maternal mortality as a human rights issue

10. Although the need to improve women's status, educate communities, and strengthen and expand antenatal care, delivery care and post-partum care were clearly recognized at the Safe Motherhood Conference, held in Nairobi in 1987, this approach to programmes was not always taken up by key actors. Instead, many donors focused on health sector interventions to increase access to professional medical care.[13]

11. When the Programme of Action of the International Conference on Population and Development[14] defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity in all matters relating to the reproductive system and to its functions and processes",[15] it incorporated maternal morbidity and mortality into the discourse on human rights. This rights-based approach was echoed by the Beijing Platform for Action[16] adopted by the Fourth World Conference on Women in 1995.[16] The commitment to reduce maternal mortality was again reiterated in 2000 at the Millennium Summit at which the elimination of maternal mortality was established as Millennium Development Goal 5, with its targets of reducing the maternal mortality ratio by 75 per cent between 1990 and 2015 and achieving universal access to reproductive health by 2015.

12. Human Rights Council resolution 11/8, entitled "Preventable maternal mortality and morbidity and human rights",[17] and resolution 15/17, entitled "Preventable maternal mortality and morbidity and human rights: follow-up to Council resolution 11/8",[18] are particularly noteworthy for renewing the call, and deepening the normative basis, for addressing maternal mortality as a human rights issue. Resolution 11/8 affirmed that addressing maternal mortality and morbidity required the effective promotion and protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health (para. 2); and resolution 15/17 encouraged States to take action at all levels to address the interlinked root causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate health-care services, information and education and gender inequality, and to pay particular attention to eliminating all forms of violence against women and girls (para. 7).

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[13] Ann M. Starr, "Safe motherhood initiative: 20 years and counting", *Lancet*, vol. 368, No. 9542 (30 September 2006), pp. 1130-1132.

[14] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[15] Ibid., para. 7.2.

[16] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

[17] See *Official Records of the General Assembly, Sixty-fourth Session, Supplement No. 53* (A/64/53), chap. III.A.

[18] Ibid., *Sixty-fifth Session, Supplement No. 53A* (A/65/53/Add.1), chap. II.

13. These recent resolutions have built on the normative foundation provided by the Convention on the Elimination of All Forms of Discrimination against Women,[19] which in article 12 calls on States parties to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

14. It is important to recognize the role that civil society has played in catalysing the emergence of the strong human rights perspective on maternal mortality. During the 2007 Women Deliver Conference, civil society led the transition in discourse from a focus on providing services to one centred on developing a human rights approach.[20] Its engagement and advocacy fuelled the adoption of Human Rights Council resolution 11/8.

15. Family Care International, the Global Health Council, the International Initiative on Maternal Mortality and Human Rights, the Safe Motherhood Initiative, and Women Deliver have been engaged by civil society to actively draw attention to the need for a better understanding and improved knowledge of maternal health rights among health-care professionals and policymakers.

16. A joint project by the Center for Economic and Social Rights and the Instituto Centroamericano de Estudios Fiscales (Guatemala) is one of many examples reflecting civil society's influence on government efforts to bring a human rights perspective into policymaking on maternal health. This project resulted in the enactment of a national maternal health law.[21]

IV. Initiatives, programmes and activities for addressing maternal mortality and morbidity

17. As noted in the report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights (A/HRC/14/39), an exhaustive overview of all major existing global initiatives and activities to address preventable maternal mortality and morbidity would be overwhelming in terms of length (para. 45). The present section therefore presents a synopsis of activities, programmes and initiatives of Member States, the United Nations system and civil society.

18. The above-mentioned report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights and the report of the Office of the High Commissioner on practices in adopting a human rights-based approach to eliminate preventable maternal mortality and morbidity and human rights (A/HRC/18/27 and Corr.1 and Corr.1/Rev.1) provide a useful context within which to view initiatives and programmes designed to address maternal mortality since they elaborate on key issues identified in Human Rights Council resolutions 11/8 and 15/17. In particular, in paragraph 3 of document A/HRC/18/27, the Council noted that, with respect to a

[19] United Nations, *Treaty Series*, vol. 1249, No. 20378.

[20] See http://www.womendeliver.org/conferences/2007-conference/ (accessed 20 December 2011).

[21] See Center for Economic and Social Rights, "Best practices in addressing maternal mortality from a human rights perspective: a framework for monitoring policies and resources for MMM prevention in Guatemala", p. 1.

human rights approach to addressing maternal mortality, State obligations are underpinned by seven specific human rights principles: equality and non-discrimination, participation, empowerment, transparency, sustainability, international cooperation and accountability.

19. Further, in paragraph 5 of document A/HRC/18/27 five features common to a human rights approach to addressing maternal mortality and morbidity were identified:

(a) Broad social and legal changes to enhance women's status by promoting gender equality and eliminating harmful practices;

(b) Increasing access to contraception and family planning to enable women and adolescent girls to make decisions regarding their sexuality and fertility, including delaying and limiting childbearing and preventing sexually transmitted infections, including HIV/AIDS;

(c) Strengthening health systems and primary health care to improve access to, and use of, skilled birth attendants and emergency obstetric care for complication;

(d) Addressing unsafe abortion for women;

(e) Improving monitoring and evaluation of State obligations to ensure the accountability of all actors and to implement policies.

20. While some Member States contributing to this report have described initiatives that address several of these actions, many focused on initiatives and activities for strengthening health systems so as to improve access to care. There were fewer mentions of activities geared towards introducing the broad legal changes required to address the root causes of maternal mortality and morbidity. Initiatives designed to address unsafe abortion were rarely reported; and there was little to suggest monitoring of State obligations towards the accountability of all actors.

A. Initiatives of Member States

21. Austria's mother-and-child health programme assures medical care during pregnancy. Women undergo six clinical examinations. Since 2010, an additional ultrasound examination, and an HIV test, as well as an oral glucose test, have been added to the tests administered to pregnant women.

22. In Belgium, female genital mutilation is considered a fundamental violation of women's and girls' rights. Belgium has ratified a large number of international treaties that condemn reproductive rights violations, including female genital mutilation. The national plan of action 2010-2014 against partner and intra-familial violence also addresses female genital mutilation and lays out means of protecting and supporting migrant reproductive rights. Programmes are in place to educate service providers and migrants on their health and reproductive rights.

23. Chad promotes the reproductive health of women and girls. The right to health is recognized in article 37 of the Constitution. Female genital mutilation is condemned and measures are in place to protect those infected with HIV or living

with AIDS. Chad has also adopted a road map to accelerate the reduction of maternal mortality.

24. The Congo focuses on controlling tuberculosis, ensuring the rights of those living with HIV/AIDS, and treating malaria among pregnant women. The National Plan for Development and Health (2007-2011) aims at strengthening the health system, reducing maternal mortality as well as morbidity, improving human resources in the health sector, and increasing community participation and partnership for health. Together with the United Nations Population Fund (UNFPA), WHO, the United Nations Children's Fund (UNICEF) and civil society organizations, the Congo launched in 2010 the campaign to accelerate the reduction of maternal mortality in Africa. The principal objective is to improve the availability and utilization of quality health services for women in order to reduce maternal mortality. Emphasis has also been placed on data-collection procedures so as to broaden the knowledge base and improve intervention strategies with regard to maternal mortality.

25. The Dominican Republic has launched several programmes designed to preserve the health of women and reduce maternal mortality. These programmes aim to provide better obstetric care for women and raise awareness on the causes of maternal mortality. There are also policies in place for reducing unwanted pregnancies, maternal mortality, violence and HIV/AIDS among women and adolescents. These strategies are empowering women to play an active role in health and reproductive care.

26. In Ecuador, Government efforts have focused on broadening the knowledge base encompassing causes of maternal mortality and morbidity and on providing better health services for women and girls so as to reduce HIV, sexually transmitted diseases, uterine cancer and intra-familial violence.

27. A new health-care act in Finland, in force since May 2011, obligates municipalities to organize maternity health services for all pregnant women and their families within the residential area. Services include follow-up and promotion of the health of pregnant women. Efforts are under way to expand professional and sectoral collaboration during pregnancy both in maternity hospitals and within post-natal services. The role of men and boys is increasingly taken into consideration and a sexual education programme is targeted at boys and fathers.

28. In New Zealand, maternity services are free, and all women have access, without discrimination, to a comprehensive range of free or low-cost health services, including all maternal services as well as sexual and reproductive health services, counselling and support against sexual and physical violence.

29. Portugal has invested in projects that have a gender-equality focus, especially in those related to domestic violence and its implications for women's physical and psychological health. The national health system ensures all citizens nearly free access to primary care centres and public hospitals. Pregnant women have access to health facilities and care, which may have contributed to the drop in maternal mortality from 19 to 3.8 per cent between 1980 and 2008. Access to family planning by women under age 18 has been allowed since 1984, the same year in which family planning appointments and contraception became free of charge in the National Health Service. Vaccination against human papillomavirus (HPV) was introduced in the national health vaccination plan for all girls up to age 13.

30. Denmark, Italy and Japan reported mainly on their assistance to other countries and programmes. Denmark supports a number of United Nations and international organizations as well as non-governmental organizations that address maternal mortality. This includes support to UNFPA, WHO and International Planned Parenthood Federation and Family Care International. Denmark is also working with partners in support of developments in the area of midwifery, including the review and change of regulations and practices so as to empower mid-level providers who perform life-saving procedures. Denmark addresses sexual and reproductive health and rights through several bilateral health sector programmes.

31. Ensuring maternal health is a priority in Italy's health policy, especially with respect to assistance to other Member States. Italy supports efforts to ensure universal access to health care and effective and efficient health services across a number of countries. Since 2004, it has focused on female genital mutilation, providing more robust bilateral and multilateral financial assistance in order to reach women in need in African countries where the practice exists. Domestically, the Ministry of Health has issued recommendation No. 6/2008 for the management of clinical risk during labour and delivery. In December 2010, an agreement was signed on the guidelines for the promotion and improvement in the quality, safety and appropriateness of care delivery for childbirth and reduction in caesarean sections. This agreement addresses, among other issues, the high number of caesarean sections performed in Italy which could heighten the risk of maternal morbidity and mortality.

32. Japan supports a safe motherhood project in Bangladesh. The project aims to improve the health of mothers, pregnant women and newborn babies through strengthening capacities of health management and improving facility-based health services. The project, which also facilitates the creation of community support groups for mothers and pregnant women, recorded significant increases in the proportion of women accessing emergency obstetric care when they experienced complications during pregnancy and delivery.

33. Malaysia has identified various stages for a broad-based service approach to maternal mortality. Government agencies in collaboration with UNFPA, and civil society organizations, have made inroads in improving reproductive health. Workshops for obstetricians and paramedics on gender and rights and reproductive and maternal health have been conducted with a view to clarifying the rights-based and gender-sensitive approach to maternal health. Under the National Family Planning Programme, cafeteria-type services are provided to ensure that clients are offered a wide choice of safe, effective, affordable and acceptable methods of contraception at the 56 clinics located throughout the country. Mobile clinics are used to reach women in marginalized areas and the urban poor.

34. The Government of Namibia developed a road map to accelerate the reduction of maternal and child morbidity and mortality. The road map targets all women, including those at high risk during pregnancy, labour, delivery and post-partum. Efforts to strengthen health systems include capacity-building for health workers in the area of maternal, perinatal and neonatal death reviews. In addition, training has been offered to traditional birth attendants to facilitate the recognition of danger signs and enhance women's timely referral to health facilities.

35. In Saint Vincent and the Grenadines, maternal mortality is mainly due to obstetric complications such as eclampsia and obstetric trauma. Policies are in place to effectively manage services for prenatal, antenatal and post-natal clients at district and central levels. Access to prenatal services is affordable and primary health care is free. In light of the relationship among education, health and economic empowerment, major strides have been made in eliminating the gender disparity in primary and secondary school education. Efforts to strengthen data and knowledge include regular presentation and discussion of perinatal and maternal health statistics, and the implementation of the national health information system.

36. Sweden recognizes the right of women to decide freely and responsibly in matters involving their own bodies. In July 2010, the Government adopted a new policy which highlights maternal health in the context of sexual and reproductive health and rights. Through the Swedish International Development Agency, special efforts are being made to support the achievement of Millennium Development Goal 5 through a broad sexual and reproductive health rights approach. Sweden also supports initiatives such as Reproductive Health Access, Information and Services in Emergencies (RAISE) designed to improve access to comprehensive reproductive health care, including the provision of emergency obstetric care, in conflict, post-conflict and crisis situations.

37. In the Syrian Arab Republic, it is estimated that in 2009, the proportion of births with professional assistance had risen to 96.2 per cent from 76.8 per cent in 1993. The numbers of women of reproductive age per obstetrician fell from 966 in 1993 to 666 in 2008. Given the evidence from various surveys that an improved economy, the eradication of poverty and increased levels of female education increase women's acceptance and utilization of available health services, the Syrian Arab Republic has invested in poverty eradication and empowerment of women, and prioritizes these goals in the tenth five-year plan (2005-2010). There is growing concern in Syrian society over issues related to violence against women. Efforts to confront this issue, in particular domestic violence, are being intensified.

38. Uruguay has placed emphasis on collecting sector-specific statistics on maternal mortality. The efforts to confront maternal mortality are in evidence in the work of Uruguay's 2006 National Commission for Reduction of Obstetric Morbidity which focuses on vigilance and data collection in its effort to reduce obstetric morbidity.

B. United Nations system initiatives

39. United Nations entities, by virtue of their diverse mandates, have implemented activities, programmes and initiatives encompassing a wider range of the elements of a human rights approach, as identified in paragraph 19. Initiatives have included awareness-raising, education and capacity-building (the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNFPA, UNICEF and WHO); promoting participation and leadership and addressing the social, cultural and economic determinants of maternal health (United Nations Development Programme (UNDP)); addressing HIV/AIDS (UNAIDS); and addressing the special needs of women in conflict and post-conflict settings (Office of the United Nations High Commissioner for Refugees (UNHCR)). Despite the broader focus, as with Member States, a strong medical care/service-provision orientation remains.

40. UNFPA has addressed the broad context of maternal mortality and morbidity by enhancing the awareness of girls' rights through its support of a project in Ethiopia that provides education to adolescent girls aimed at helping them delay marriage. In 2008, it launched an Investing in Midwifery Programme with the International Confederation of Midwives as an entry point for the management of human resources for health (including training, recruitment, deployment, retention and supervision). The number of participants in this programme has been scaled up from 11 to some 30 countries in Africa, Asia and Latin America. National midwifery strategies have been drafted in Afghanistan, Bangladesh, the Sudan and Uganda. UNFPA has provided support to Governments in carrying out national emergency obstetric and newborn care needs assessments in over 20 countries.

41. Together with partners, UNFPA launched the global Campaign to End Fistula. It has helped over 20,000 women and girls to recover from fistula and rebuild their lives through access to surgical treatment and care, and provision of social reintegration services.

42. Aware that unplanned pregnancies and unsafe abortions are major causes of maternal mortality and morbidity, UNFPA, through its Global Programme on Reproductive Health Commodity Security, supports family planning programmes in countries with high unmet need for family planning and low contraceptive prevalence. It has provided support to 45 countries, thereby contributing to significant increases in the contraceptive prevalence rate in these countries.

43. UNDP has focused on building robust health systems through its work in strengthening governance, institutions and management capacity, as well as through its coordinating and convening role in bringing together multiple partners and resources at national and local levels. As part of its mandate to address cross-cutting gender-equality issues which influence all the Millennium Development Goals, UNDP works through three pillars: (a) promoting national leadership, sustainable financing, effective development assistance and aid coordination for maternal and reproductive health; (b) addressing the social, cultural and economic determinants of maternal and reproductive health; and (c) responding to governance, institutional and management capacity bottlenecks that impact on the health sector.

44. UNDP has been engaged at various levels. In Tunisia, it worked in collaboration with UNICEF and UNFPA to prepare the first Millennium Development Goal report, which was a critical advocacy tool for scaling up efforts to reduce maternal mortality. In Ghana, it promoted national leadership and sustainable financing for Millennium Development Goal 5 by supporting the strengthening and alignment of the second Growth and Poverty Reduction Strategy. In India, UNDP supports a creative public-private partnership to scale up LifeSpring Hospitals, a chain of small hospitals providing low-income women in India with access to maternal and child health services. In Kenya, it leads an inter-agency HIV initiative, Universal Access for Women and Girls Now!, to help the Government scale up comprehensive post-rape care services in health facilities. A programme is in place in Uganda to target bottlenecks and strengthen coordination of the Goal 5 response.

45. UNAIDS has worked towards the elimination of mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths. The UNAIDS Strategy 2011-2015: Getting to Zero, which was adopted in December 2010, includes a goal to eliminate the vertical transmission of HIV and reduce

AIDS-related maternal mortality by half, by 2015. The Strategy prioritizes gender equality and human rights as one of its three overall pillars for achieving universal access to HIV prevention, treatment, care and support and the Millennium Development Goals.

46. The gender-equality component of the UNAIDS Strategy is being operationalized through the UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV in collaboration with civil society in over 80 countries.[22] Women's and girls' access to HIV and sexual and reproductive health services is a key component of the Agenda on Women and Girls. UNAIDS, together with the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and co-sponsors, is providing support to Member States in promoting strategies for addressing gender-based violence and in engaging men and boys in HIV strategic plans of 14 countries.[23]

47. Together with UN-Women, UNAIDS organized a high-level consultation on sexual and reproductive health and rights of women and girls living with HIV during the fifty-fifth session of the Commission on the Status of Women in February 2011. The consultation shed light on the factors that deter women from accessing HIV, antenatal, and sexual and reproductive health services.

48. During the High-level Meeting on AIDS, held in June 2011, UNAIDS developed and launched the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015,[24] which provides the foundation for country-led action to eliminate vertical transmission and reduce maternal mortality in low- and middle-income countries. The UNAIDS platform "Treatment 2.0" will enable delivery systems to be further decentralized and integrated with other areas of health care such as maternal and child health and tuberculosis services.

49. Promoting education and literacy is at the heart of the work of UNESCO in support of the achievement of Millennium Development Goal 5. The elimination of maternal mortality and morbidity is addressed through multidisciplinary responses, including assuring quality functional literacy classes; identifying the diverse social and cultural structures that influence the lives of women and girls; and studying women's health and status and their association with pregnancy, childbirth and neonatal care. Attention has also been given to increasing the awareness of, and capacity for protecting, the rights of women and girls, including reproductive rights and maternal health.

50. According to UNICEF (in a contribution to the present report), women who have been to school are less likely to die during childbirth and more likely to take good care of their children. UNICEF has therefore been supporting projects to empower girls and women through, inter alia, ensuring that girls stay in school.

[22] See the report on the implementation of the Agenda (UNAIDS/PCB(28)/11.5) submitted to the Programme Coordinating Board of UNAIDS at its twenty-eighth session, held from 21 to 23 June 2011.

[23] Cambodia, Côte d'Ivoire, Haiti, India, Jamaica, Kenya, Liberia, Pakistan, Papua New Guinea, Rwanda, Serbia, South Africa, the Sudan and Ukraine.

[24] *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015* (Geneva, 2011).

51. Improving maternal health and empowering women include ensuring involvement of partners, communities and Governments in achieving this objective. In India, UNICEF supported the Government in determining the underlying causes of maternal mortality. The Maternal and Perinatal Death Inquiry and Response (MAPEDIR) initiative used a tool for identifying the personal, familial, sociocultural, economic and environmental factors that contribute to such deaths.

52. Various entities have contributed to initiatives for reducing maternal mortality and morbidity through education, advocacy, training and research. Formal publications (WHO) and capacity-building and awareness-raising at the country level (International Labour Organization (ILO) and UNESCO), as well as liaison with the media and media outreach (Department of Public Information of the United Nations Secretariat) have been utilized.

53. WHO has supported policy-relevant research, providing important tools and evidence which contribute significantly to expanding access to essential sexual and reproductive health interventions, including family planning, and maternal health services, as well as promoting women's empowerment. UNAIDS supported a study of access to reproductive and maternal health services by women living with HIV in six countries in Asia. UNFPA supports advocacy on Millennium Development Goal 5 at the global level.

54. UNHCR has strengthened its maternal health programme, including emergency obstetric and neonatal care at all levels, encompassing the community, labour rooms and referral facilities. Services have been provided for internally displaced persons, urban refugees and returnees. UNHCR continues to promote and support the implementation of a minimum initial service package at the immediate onset of new emergencies, which scales up to a comprehensive and integrated sexual and reproductive health programme that increases access to quality emergency obstetric care, while expanding family planning opportunities and services for sexually transmitted infections including HIV/AIDS.

C. Major global initiatives

55. Of recent global initiatives, the most promising with respect to addressing a range of issues at the root of persistent maternal mortality is the Every Woman Every Child initiative, which was launched by the United Nations Secretary-General under the Global Strategy for Women's and Children's Health, with the aim of saving the lives of 16 million women and children by 2015. The Global Strategy, with a budget of $40 billion, constitutes an unprecedented global effort which mobilizes and intensifies international and national action by Governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children. The Global Strategy has devised a road map on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children. In May 2011, 16 countries announced their commitments to the initiative, largely in the form of budgetary increases for maternity and prenatal care.

56. Every Woman Every Child is aware of the link between Millennium Development Goals 5 and 4, and all the other Goals, and recognizes that the empowerment of women and gender equality improve the health of women and children through the resultant increase in the range of reproductive choices,

reduction of child marriages and tackling of discrimination and gender-based violence. In connection with the launch of this initiative, a Commission on Information and Accountability was established to ensure effective and efficient delivery and use of the resources raised.

57. The Group of Eight (G8) Muskoka Initiative supports strengthened country-led national health systems in developing countries designed to enable delivery of key interventions along the continuum of care. It emphasizes strengthening health systems, expanding sexual and reproductive health services, including family planning, addressing gender inequality and promoting the human rights of girls and women. Through this initiative, G-8 Governments will provide 5 billion United States dollars between 2010 and 2015. An additional $2.3 billion will come from other Governments — the Netherlands, New Zealand, Norway, the Republic of Korea, Spain and Switzerland — and the United Nations Foundation and the Bill and Melinda Gates Foundation.

58. To accelerate efforts to save the lives of women and newborns, WHO, UNFPA, UNICEF and the World Bank, in 2008, issued a Joint Statement on Maternal and Newborn Health and committed to redoubling their joint efforts in this regard. They were later joined by UNAIDS. Commonly known as the H4+, these organizations have embarked on a major programme of work on behalf of the 50 countries with the highest newborn and maternal health burden.

59. The Global Health Initiative launched by the President of the United States of America, Barack Obama, will be implemented in all countries receiving United States health assistance. Eight countries — Bangladesh, Ethiopia, Guatemala, Kenya, Malawi, Mali, Nepal and Rwanda — will receive additional technical, management and financial resources to enable them to quickly implement the approach set out by the Initiative, including integrated programmes and investments over the entire spectrum of infectious diseases, and maternal and child health, family planning, and health systems activities.

60. The Mandang Commitment emerged from the 2009 biennial Meeting of Ministers of Health for the Pacific Island Countries. The Addis Call to Urgent Action for Maternal Health, launched in 2009, called for the enactment and enforcement of laws and policies on a minimum age at marriage of 18 years, on respecting girls' human rights and on preventing risks associated with child marriage and adolescent pregnancies, and ensuring that health systems were gender-sensitive and culturally sensitive and community-oriented, and created demand for provision of effective services and infrastructure. The Addis Ababa Statement of Commitment, which emerged from the Fourth International Parliamentarians' Conference on the Implementation of the International Conference on Population and Development Programme of Action (27 and 28 October 2009), firmly recognized the promotion of gender equality and the empowerment of women as one of nine areas of focus towards achieving Millennium Development Goal 5.[25]

61. The International Initiative on Maternal Mortality and Human Rights was launched in 2007 as the first civil society human rights effort aimed at reducing

[25] Others include awareness-raising and advocacy; budget and oversight responsibilities; legislative and policy responsibilities; empowerment of young people; strengthening health systems; promoting access to sexual and reproductive health, including family planning; ensuring adequate financing; and addressing climate change and emerging population issues.

maternal mortality. The Initiative was launched by a partnership of international, regional and national civil society organizations committed to a comprehensive human rights approach to maternal mortality, including a call for greater political will on the part of Governments and donors in respect of taking the necessary steps to reduce maternal mortality, and in turn, more and better accountability mechanisms for ensuring that women's right to maternal health becomes a reality.[26] With projects in India, Kenya and Peru, the International Initiative seeks to increase understanding of how to integrate human rights ideas and approaches into maternal mortality work at national, subnational and local levels. It also seeks to build bridges among human rights, public-health and women's rights groups.

V. Initiatives to strengthen data and knowledge on maternal mortality

62. In developing countries where accurate medical records may not exist, where the pregnancy status of a woman before her death may be unknown or concealed owing to social, cultural or religious factors, and where cause-of-death data may be missing or unreliable, many maternal deaths are likely to be missed. In the absence of reliable civil registration systems, indirect methods of estimation have been used. Yet, reliable data that are disaggregated by sex and age are essential for addressing maternal mortality from a human rights and gender-equality perspective.

63. There has been progress in ensuring linkages in this area across initiatives which have slowly moved away from an approach based on the endeavours of individual United Nations entities or academics towards one that is more integrated and harmonious.

64. The Maternal Mortality Estimation Inter-Agency Group, composed of WHO, UNICEF, UNFPA and the World Bank, and an independent Technical Advisory Group, now works to review and generate estimates of maternal mortality. It has developed maternal mortality estimates using statistical modelling for countries where no reliable data exist and has updated existing estimates.

65. The United Nations Statistics Division has continued to maintain and improve the Millennium Development Goals Indicators database and website,[27] working in this regard through the Inter-Agency and Expert Group on Millennium Development Goals Indicators and its thematic subgroups. In particular, international organizations responsible for the production of estimates and the compilation of indicators for monitoring Goal 5 and the two targets related thereto have strengthened their collaboration and carried out a number of initiatives at the regional and international levels, including training workshops on estimation methods and indicators metadata, for experts from national statistical offices and health ministries; consultations with national counterparts on the production of estimates; and data analysis and dissemination efforts.

66. Member States also continue to work to improve national data collection and analysis in the area of maternal mortality and morbidity. In New Zealand, the Perinatal and Maternal Mortality Review Committee collects data on all perinatal

[26] See http://righttomaternalhealth.org/.

[27] http://mdgs.un.org.

and maternal deaths in the country and produces a report that identifies contributing factors and deaths that were possibly avoidable. Data are also collected on maternal morbidity. A maternity standards guide has been established in the context of the provision and monitoring of maternity services. These data are provided regularly to WHO, the Organization for Economic Cooperation and Development (OECD) and Eurostat, thus allowing close monitoring of progress.

VI. The catalytic role of UN-Women

67. With its mandate to lead and coordinate the gender-equality work across the United Nations system, UN-Women works to support the forging of strong links across entities with a view to promoting gender equality and the empowerment of women in all areas of work.

68. Without seeking to replace or duplicate the work of other entities that have clear comparative advantage in the area of maternal mortality, UN-Women will help to advance women's leadership and participation, ensuring that countries have access to the best knowledge and technical expertise so as to enable a strong gender-equality and women's empowerment perspective to emerge. Through its emphasis on women's economic empowerment, UN-Women will strengthen capacity at the country level so as to ensure a gender equality-responsive implementation of programmes and projects on maternal mortality.

69. A core aspect of the work of UN-Women comprises its efforts to address and reverse gender inequality and gender stereotyping which are at the basis of prevailing and persistent high maternal mortality. In this respect, the emphasis of UN-Women is complementary to the focus of other entities that are addressing the direct causes of maternal mortality and morbidity. The support provided by UN-Women to Member States with respect to developing gender-responsive budgets will also ensure that adequate resources are allocated to gender equality in development activities. UN-Women promotes the participation of women in decision-making in all contexts, including post-conflict ones, where the reproductive health and rights of women are subject to particular risks and where sexual violence and rape contribute to exceptional levels of maternal morbidity and mortality. Through its emphasis on women's economic empowerment, UN-Women will strengthen women's capacity to make decisions concerning their reproductive health, including with respect to accessing reproductive health services and commodities.

70. UN-Women's goal of increasing the level of women's leadership and participation is central to the elimination of maternal mortality. The participation and leadership of women are essential to achieving the full human rights and gender-equality perspective required to address maternal mortality. They ensure that interventions are familiar, fully owned and remain relevant. Effective policies and programmes for addressing maternal mortality and morbidity cannot be designed without the participation of women.

71. Two important roles for UN-Women, as outlined in its strategic plan 2011-2013 and its Development Results Framework, lie in ensuring that the global policy and normative framework for gender equality and women's empowerment are reaffirmed, strengthened and deepened and in increasing the extent to which sectoral global policy and normative frameworks reflect gender-equality and women's

empowerment perspectives. To this end, UN-Women will work with other entities to ensure that a gender-equality perspective emerges and is strengthened in sectoral work conducted to support the elimination of maternal mortality. UN-Women will also promote a link between relevant normative agreements on maternal mortality and operational experiences, including through the Commission on the Status of Women, and in the work of the broader intergovernmental machinery.

VII. Conclusions and recommendations

72. In recent years, the importance of a human rights and gender-equality approach to achieving Millennium Development Goal 5 has been clearly acknowledged and codified in intergovernmental norms. From this perspective, it is recognized both that a medical approach and availability of services, while essential, are insufficient and that a gender-equality approach is needed to address the root causes of maternal mortality and to ensure that quality services are accessible to and affordable by all.

73. According to the Office of the United Nations High Commissioner for Human Rights, the most effective examples of the human rights approach to addressing maternal mortality involve a combination of sustained efforts to address the underlying causes of maternal mortality and a strengthening of government commitments to ensuring better access to high-quality health care and fostering the empowerment of women.

74. The present report suggests that a consistent and sustained human rights approach that emphasizes a comprehensive set of interventions that are responsive to human rights and gender equality and the empowerment of women has not quite emerged. Existing initiatives and programmes have undoubtedly contributed to recently recorded reductions in maternal mortality; however, there is no evidence of the application of this sustained approach.

75. In initiatives and programmes undertaken by Member States, and to a lesser extent by the United Nations system, maternal mortality and morbidity are being addressed primarily as medical issues. Comprehensive initiatives to address well-known challenges such as malaria are lacking. Laws have been adopted in some countries to halt female genital mutilation, but there is little evidence of a comprehensive global approach to this violation of the rights of girls and women as well as to addressing all forms of violence against women and girls in the context of pregnancy and childbearing.

76. The slow emergence of a sustained human rights and gender-equality approach that addresses all the elements identified by the Human Rights Council as being essential to this approach can be attributed to many factors.

77. Member States and United Nations entities have themselves reported various constraints on their efforts to eliminate maternal mortality, including high levels of illiteracy, cultural and religious obstacles, poor health infrastructure, inadequate training for health personnel, and challenges associated with high population growth.

78. Geographical isolation resulting in high costs of serving dispersed populations, including rural women, has constrained progress of some Member States. Shortage of staff at the referral levels, insufficient funding for maternal and child health

programmes, and lack of maternity waiting homes in some regions, in addition to lack of skilled personnel and their unequal distribution between urban and rural areas, have been reported.

79. Although a number of countries have achieved low levels of maternal mortality, significant pockets of vulnerable and disadvantaged groups still remain. There are special challenges with respect to the provision of adequate maternity care and reproductive health services for particularly vulnerable groups, namely, rural women; women with HIV/AIDS; adolescents; women with disabilities; and indigenous women. The human rights of these groups are often disregarded, particularly in the context of pregnancy and childbirth.

80. The Permanent Forum on Indigenous Issues has thus repeatedly recommended that measures devised to address the maternal health of indigenous women should first of all foresee the need for culturally appropriate health services. Services must be developed with respect for and in accordance with their traditions of health and well-being, and provided in the native languages and in a culturally appropriate setting. Women should be able to participate in shaping their own health care, including antenatal care and delivery.

81. Similarly, evidence concerning reproductive health services available to women with disabilities suggests that those women are often excluded from family planning and education (including sexual education) services. Indeed, service providers may believe incorrectly that women with disabilities are not in need of reproductive health services, because they are either not sexually active or not capable of becoming pregnant. Health-care providers need to acquire education and experience in working with patients with disabilities so as to ensure that the rights of women with disabilities are respected during pregnancy and post-partum.

82. **In view of the clear evidence of a fragmented approach to addressing the elimination of maternal mortality and morbidity, a concerted effort is required to accelerate the emergence of a clear-cut and sustained human rights approach. This approach must be comprehensive and holistic and include a broad range of programmes as well as services.**

83. **Broad social changes are needed to address the vulnerability of women and girls to discrimination, abuse and gender-based violence, including female genital mutilation. Access to education and information on reproductive health care and services as well as interventions to address the threat, inter alia, of malaria, anaemia and HIV/AIDS are needed.**

84. **Quality care before, during and after pregnancy must be provided, and women's and girls' needs for adequate nutrition, clean water and sanitation, as well as the need for access by pregnant women to prenatal and post-natal care, must be met. Provision must also be made for access to comprehensive primary health services, and adequate infrastructure, including the transportation and communication systems required to handle emergency obstetric events.**

85. **Given the strong interrelationships among root causes, efforts to address maternal mortality must also focus on meeting Millennium Development Goals 3, 5 and 6 jointly in order to combine the benefits of promoting gender equality and empowerment of women; improving maternal health; and combating HIV/AIDS, malaria and other diseases. While working towards the elimination of new HIV infections among women and girls, it is important to ensure that**

pregnant women with HIV/AIDS are protected from the discrimination in service and care that could jeopardize their lives as well as the lives of their offspring. Access to antiretroviral treatment for those who are infected must be ensured.

86. **Efforts to eliminate all forms of discrimination against women and girls, and to end all forms of violence, including female genital mutilation, against women and girls must be strengthened. These efforts must be backed by appropriate legislation and enforcement.**

87. **Affordable, accessible care, particularly emergency obstetrics care, is essential to a rights-based approach to eliminating maternal mortality. Effective treatment and follow-up must be provided in event of an emergency obstetric event or maternal morbidity.**

88. **Finally, the promotion of gender equality and the empowerment of women and adolescent girls within their communities, so as to enable them to participate in all aspects of decision-making on their reproductive lives, maternity, post-natal well-being and sexual and reproductive health, must become key elements of all human rights-based initiatives to address maternal mortality and morbidity.**

89. **Implementing these interventions will require renewed dedication and a commitment of resources, as well as a solid system of accountability. The Commission on Information and Accountability of the Every Woman Every Child Initiative constitutes a good model in this regard.**

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Economic empowerment of women

Report of the Secretary-General

Summary

The present report has been prepared in response to the request of the Commission on the Status of Women, in its resolution 54/4 on women's economic empowerment, that the Secretary-General submit, to its fifty-sixth session, a report on the implementation of that resolution. The report examines the economic policy framework on the economic empowerment of women and makes recommendations for future action.

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I. Introduction

1. In its resolution 54/4, the Commission on the Status of Women proposed some measures that Member States and other stakeholders could take to promote women's economic empowerment and requested that the Secretary-General report to the Commission at its fifty-sixth session on the implementation of the resolution. The present report incorporates contributions by Member States[1] and organizations of the United Nations system,[2] drawing on evidence found in the publications of United Nations entities and other sources, and concludes with recommendations for future action for the consideration of the Commission.

2. Women's economic empowerment, both as a process and as a functioning reality, enables women to enjoy economic rights and make decisions that impact their own lives and influence others. It opens up opportunities for women to achieve other dimensions of empowerment, including political and social empowerment. In addition to its intrinsic value, women's economic empowerment can contribute to the achievement of other key development goals.[3] Achieving women's economic empowerment requires a comprehensive and coherent approach that pulls together institutions, policy instruments and monitoring frameworks, including the influence and leadership of women and groups working for their rights. It entails valuing, measuring and respecting women's work.

3. The report also examines the macroeconomic policy environment and analyses the situation of women as workers, entrepreneurs and decision makers, including their contribution to the economy and human well-being. It makes the case that women's economic empowerment is essential if societies worldwide are to exit the current global economic downturn and deliver balanced and sustainable global growth, with equality, justice and dignity for women and men. It focuses on areas where further action is needed to accelerate women's economic empowerment, including macroeconomic policy, trade, work and employment, entrepreneurship and economic decision-making. While access to and control over assets underpins women's economic empowerment, these matters are not considered in the present report in order to avoid duplication with other reports on the priority theme.

4. The two reports of the Secretary-General for the fifty-sixth session of the Commission on the priority theme (E/CN.6/2012/3 and E/CN.6/2012/4) focus on economic empowerment of rural women and advancing rural women's

[1] Contributions were received from the Governments of Austria, Colombia, Djibouti, Finland, Germany, Indonesia, Italy, Japan, Latvia, Poland, Senegal, South Africa, the Sudan, Sweden, Turkey, and the United Kingdom of Great Britain and Northern Ireland.

[2] Contributions were received from the Economic Commission for Europe, the Economic Commission for Latin America and the Caribbean, the Economic and Social Commission for Western Asia, the Food and Agriculture Organization of the United Nations (FAO), the International Fund for Agricultural Development (IFAD), the International Labour Organization (ILO), the International Training Centre of the International Labour Organization (ITC-ILO), the United Nations Conference on Trade and Development (UNCTAD), the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the United Nations Population Fund (UNFPA), the Office of the United Nations High Commissioner for Refugees (UNHCR), the Department of Public Information and the secretariat of the Permanent Forum on Indigenous Issues.

[3] See World Bank, *World Development Report 2012: Gender Equality and Development* (Washington, D.C., 2011).

empowerment through gender-responsive institutions. The reports highlight areas where further efforts are needed to accelerate women's economic empowerment, such as productive resources, including land, property and finance, and markets, the agricultural sector, sustainable development, service delivery and rural institutions. Member States are encouraged to consider these reports together so as to obtain an overview of women's economic empowerment issues.

5. The Beijing Platform for Action (1995), the outcome of the twenty-third special session of the General Assembly (2000) and the Convention on the Elimination of All Forms of Discrimination against Women provide the policy, legal and institutional framework for advancing women's economic empowerment. The international community has also made strong and comprehensive commitments to women's economic empowerment at other intergovernmental processes, including the Millennium Summit (2000), the International Conference on Financing for Development (2002), the Follow-up International Conference on Financing for Development (2008) and the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (2010).

6. In 2010, at the eleventh session of the Regional Conference on Women in Latin America and the Caribbean, States committed themselves to implementing actions to attain greater economic autonomy and equality in the workplace. In the Programme of Action for the Least Developed Countries for the Decade 2011-2020, adopted at the Fourth United Nations Conference on the Least Developed Countries, held in Istanbul, Turkey, in 2011, States promoted the empowerment of rural women as critical agents for enhancing agricultural and rural development and food and nutritional security and for ensuring their access to productive resources.[4] In addition, at the High-level Policy Dialogue on Women and the Economy held by the Asia-Pacific Economic Corporation (APEC) forum in 2011, member States agreed to take concrete actions to realize the full potential of women, integrate them more fully into APEC economies, harness their talents, remove barriers that restrict their full economic participation and maximize their contributions towards economic growth. Human rights treaties, bodies and mechanisms have also addressed the issue. In 2011, the International Labour Organization (ILO) adopted the Domestic Workers Convention[5] and recommendation aimed at improving the working conditions of domestic workers worldwide.

II. The macro economy

7. The Department of Economic and Social Affairs of the Secretariat and IMF estimate global growth in 2010 at 4 to 5 per cent, but there is a consensus that global economic recovery from the financial and economic crisis is slowing down as a result of tensions and failures in financial markets, sovereign debt problems in Europe, commodity price fluctuations and continuing global trade imbalances. Global growth projections for 2011 and 2012 are being downgraded, and the world's richest economies are expected to grow at a rate of less than 2 per cent.[6] The financial and economic crisis, combined with volatile food and energy prices, have

[4] See A/CONF.219/3/Rev.1.

[5] See http://www.ilo.org/ilolex/cgi-lex/convde.pl?C189.

[6] See International Monetary Fund, *World Economic Outlook: Slowing Growth, Rising Risks* (Washington, D.C., 2011).

contributed to fast growing inequalities, which pose a threat to economic development, political stability, peace and security around the world.

8. Continued global economic stagnation and low growth will impede women's economic empowerment and poverty reduction, although a global recovery alone cannot guarantee their improvement. Gross domestic product (GDP) measures aggregate consumption, investment, government expenditure and net trade, but the way these aggregates are measured does not take unremunerated inputs into account. Therefore, the unpaid work of women (and men) and the "free" environmental resources that are used to produce the goods and services that society depends on do not enter the calculations of GDP or its growth. In order to truly assess progress in human well-being, GDP growth should be examined in conjunction with indicators of well-being, such as malnutrition and human development, including indicators that incorporate unpaid as well as paid work.[7]

9. In order to reduce economic and social inequalities and promote environmental protection, economic growth must be inclusive. In the 1990s, with a sustained growth in national per capita income, marginalized populations often missed out on the opportunity to improve their situation (see A/66/126).

10. Addressing women's economic empowerment is fundamental if inclusive pro-poor growth is to be secured; in addition to being an issue of human rights, there is a strong economic case for promoting women's economic empowerment. The Food and Agriculture Organization of the United Nations (FAO), for example, estimates that if women had the same access to productive resources as men, they could increase yields on their farms by 20 to 30 per cent, raising total agricultural output in developing countries by 2.5 to 4 per cent, thereby contributing to both food security and economic growth.[8]

11. While significant progress has been made towards achieving some of the Millennium Development Goals, the financial and economic crisis has jeopardized progress in some developing countries. For example, a study of six Latin American countries estimated that the projected recession in 2009-2010 and a slow and gradual recovery towards pre-crisis growth levels by 2015 would leave some low-income countries further off track in their efforts to achieve the Millennium Development Goals for primary school completion, child and maternal health and access to drinking water and sanitation.[9]

12. The slow economic recovery has not delivered jobs. ILO warns that the global economy is on the verge of a new and deeper jobs recession that will delay the global economic recovery and may ignite more social unrest in many countries. Jobless growth urgently needs to be addressed and employment must be created for women and men. Ensuring a minimum level of social protection for all is critical to building fairer, more inclusive societies, based on equality of women and men, as proposed by the Social Protection Floor Advisory Group.

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[7] Jain, D. and Elson, D. (eds), *Harvesting Feminist Knowledge for Public Policy, Rebuilding Progress* (New Delhi, 2011).

[8] Food and Agriculture Organization of the United Nations, *The State of Food and Agriculture 2010-2011: Women in Agriculture, Closing the Gender Gap for Development* (Rome, 2011).

[9] Sánchez, M. and Vos, R., "Impact of the global crisis on the achievement of the Millennium Development Goals in Latin America. New York", Department of Economic and Social Affairs, Working Paper No. 74 (ST/ESA/2009/DWP/74).

13. The financial and economic crisis has already squeezed the policy and fiscal space available to Governments, notably in the developed countries, to implement counter-cyclical measures. As fiscal stimulus gives way to fiscal consolidation, economic activity is likely to slow down, compounding the impact of lower government spending. Previous long periods of low growth and slow development, for example "the lost decades" in sub-Saharan Africa and Latin America, had gender-differentiated consequences. Women usually compensate for cutbacks in public welfare expenditure and drops in household earnings by intensifying their unpaid and paid work, especially in the informal sector, where there is little or no protection of their rights.

14. Policy debates on the critical issues of how to regulate markets, generate inclusive growth, promote equitable trade, create jobs and invest in the provision of essential services are broad-based and wide-ranging, providing an opportunity for gender equality advocates to engage, to make the case for women's economic empowerment and to ensure that gender dimensions of policies and programmes are taken into account.

15. Gender analysis of fiscal policies is critical. Tax systems, for example, can create and perpetuate gender inequalities since they can influence how women and men allocate their time for formal, informal and unpaid work.[10] A recent examination of the gender dimensions of tax policies and reforms in Argentina, Ghana, India, Mexico, Morocco, South Africa, Uganda and the United Kingdom of Great Britain and Northern Ireland illustrated the distributional impacts of tax policies on women and men, the impact of tax policies and reforms on both paid and unpaid work, both among and within households, as well as the differential impact on people over their life cycle.[11] The majority of women in the developing countries fall outside the personal income tax net as they are situated in the informal economy or in formal sector occupations where earned incomes are often well below the income tax threshold. The use of tax allowances in such contexts would therefore reach only the small proportion of women that fall inside the tax net.

16. Gender-responsive budget initiatives have been instrumental in assessing the gender-sensitivity of public finance management. They have provided guidance and monitoring tools so that commitments to gender equality policies can be matched with resource allocations. Austria requires that gender budgeting be applied in all phases of federal budget management, including planning, drafting, implementation and verification. In Sweden all statistics in the budget bill are sex-disaggregated and there is a statistical annex on economic equality between women and men. The United Nations Population Fund (UNFPA) supports advocacy and capacity-building efforts in gender-responsive budgeting in some countries in Africa, including Gabon, Ghana and Nigeria.

17. The development of gender-responsive policies requires both an understanding of the distributional consequences of economic growth strategies and the monetary, fiscal, trade and investment policies that underpin them, as well as an understanding of the forces that constrain women's economic empowerment. The Gender and Economic Policy Management Initiative, a joint initiative of the United Nations

[10] Barnett, K. and Grown, C., *Gender Impacts of Government Revenue Collection. The Case of Taxation* (London, Commonwealth Secretariat, 2004).

[11] Grown, C. and Valodia, I. (eds), *Taxation and Gender Equity: A Comparative Analysis of Direct and Indirect Taxes in Developing and Developed Countries* (Routledge, New York, 2011).

Development Programme (UNDP) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) that is well-established in Africa and is currently being replicated in Central and Eastern Europe and Asia, focuses on building a critical mass of gender-aware economists to support the development, implementation and monitoring of gender-responsive macroeconomic policies and frameworks. The Economic and Social Commission for Western Asia has developed guidelines and tools for gender mainstreaming to assist ministries of labour and national machineries for gender equality. The Department of Public Information promotes the issue of women's economic empowerment in its outreach and advocacy work.

18. Many economic policies tend to overlook the gender distribution of paid and unpaid work. However, it is possible to take the gender distribution of paid and unpaid work into account in policy diagnostics and design. South Africa's child support grant, for example, helps alleviate constraints, including the need for child care, that reduce the participation of working-age women in the labour force.[12]

19. The decline in income levels associated with recessions can restrict opportunities for poor children, and thus exacerbate the intergenerational transmission of poverty.[13] Social protection programmes have helped women mitigate some of the gender-differentiated effects of the financial and economic crisis. For example, in 2009, Mexico increased the coverage and scale of the "Oportunidades" conditional cash transfer programme, to help the poor manage increasing food prices. South Africa rapidly increased the coverage of social transfers that target poor households and the Philippines responded to the crisis by scaling up a pilot programme for conditional cash transfers, reaching 6,000 households in 2008 and 1 million by the end of 2010. The Government plans to reach 4.2 to 4.3 million poor families by the end of 2012.[14]

III. Trade

20. Trade policies, through their impact on the economic and social roles that men and women play, are linked to women's economic empowerment. Transmission mechanisms include the impact of trade policy on prices, employment, wages and skills. The impact of trade policies on gender relations will vary within and between countries and between different social groups and over time.

21. Employment in the export sector provides an important source of waged employment for women in some countries and regions. ILO has estimated that women's employment accounts for 70 per cent of the 27 million jobs in export-processing zones. More recently, women's participation in trade in services has contributed not only to their own economic empowerment, but also to national competitiveness.[15] While these jobs have contributed to women's economic

[12] See Group of 20, Organization for Economic Cooperation and Development, International Labour Organization, Country Policy Briefs (2011), South Africa (www.oecd.org).

[13] Nora Lustig, "Protecting Latin America's Poor During Economic Crises", Inter-American Dialogue, Policy Brief No. 2 (February 2010).

[14] World Bank (August 2011), Social Safety Nets Respond to Crises (see http://web.worldbank.org/WBSITE/EXTERNAL/NEWS).

[15] Puri, L., "Trade in Services, Gender and Development: A Tale of Two Modes", in *Trade and Gender: Opportunities and Challenges for Developing Countries*, United Nations Sales

autonomy and status in the household, the conditions of work in these industries have often been poor, marked by persistent low wages, gender wage inequalities, extremely long hours and job instability.[16] Concerns have also been raised about the lack of occupational health and safety measures, threats to, or bans on, self-organization by workers and violence and sexual and gender-based violence and harassment.[17] Furthermore, not all work takes place in the factory or in formal employment settings since some export goods are manufactured using piece-rate work or work done in the home. In such situations wages are typically too low to enable women to move out of poverty, and there is no access to social protection.

22. The expansion of the information and communications technology (ICT) sector has increased employment opportunities for skilled women in several countries. Data-entry and data-processing work generated employment in countries, including Barbados, Jamaica and the Philippines, in past decades, and more recently software call centres and telecommunications-related work has generated employment in countries such as Malaysia and India.[3] Nevertheless, women remain heavily engaged in the manufacturing of ready-made garments: women make up more than 80 per cent of such workers in Bangladesh and more than 75 per cent in Kenya.

23. Evidence from the Middle East and North Africa region suggests that export-led industrialization and female employment are positively related. Data from ILO show that by the early 1990s, the female share of manufacturing workers was 43 per cent in Tunisia and 37 per cent in Morocco. Oil-centered industrialization, on the other hand, inhibits female employment. In Algeria, the Islamic Republic of Iran and Saudi Arabia, countries that rely heavily on oil extraction and revenues, only a small portion of the female economically active population is gainfully employed.[18]

24. Trade liberalization processes and structural adjustments may entail production and employment displacement effects.[19] For example, lowering tariff barriers entails adjustment as local enterprises may no longer be able to compete with imports. Finding new sources of work in areas that offer comparative advantage and developing export industries may take time, and the new jobs and opportunities created may be for entrepreneurs and workers with different skills than those employed in tariff-protected enterprises. Studies show that while, on balance, the gains from liberalized trade outweigh those costs, adjustment may not be gender neutral.[20]

25. Higher female employment in the export sector has been accompanied by wage gains in some cases. For example evidence from China shows that women workers receive higher wages in the new export-related industries than the older State industries, and in Bangladesh and Morocco wage discrimination against

Publication, E.04.11.D.29.

[16] Grimsrud Berik, "Gender Aspects of Trade", in *Trade and Employment from Myths to Facts* (ILO, 2011).

[17] International Labour Organization, *A Fair Globalization: Creating Opportunities for All* (Geneva, 2004).

[18] Moghadam, V. M., Modernizing Women: Gender and Social Change in the Middle East (London, 2003).

[19] Pyatt, L., "The engendering of trade for development", in *Trade and Gender: Opportunities and Challenges for Developing Countries*, United Nations Sales Publication, E.04.11.D.28.

[20] See Winters, A., "Trade liberalization and economic performance: an overview", in *Economic Journal*, vol. 114.

women in the field of textile exports was lower than in other areas of manufacturing at the early stages of liberalization, and it declined even further over time.[3] This is not, however, always the case. In Latin America, for example, evidence suggests that trade liberalization has coincided with an increase in both income and wage inequality.[16]

26. In 2009, at the onset of the financial and economic crisis, world trade fell by 11 per cent. The fragility of the recovery in many countries and the weakening demand in advanced economies implies that employment in export industries that have previously been significant sources of employment for women in several countries is threatened. In Cambodia, for example, 18 per cent of the total garment workforce, mostly made up of women, was laid off from October 2008 to May 2009.[21]

27. Gender equality is slowly getting some attention in the international trade agenda. As reported by the Organization for Economic Cooperation and Development (OECD), about 3 per cent of total "aid for trade" ($42 billion in 2008) included some gender dimensions.[22] Certain countries have made important progress in integrating gender equality into their trade initiatives: Uganda, in its national export strategy, identified constraints to women's participation in exports and incorporated measures to unlock the untapped potential of Ugandan women and increase their contribution to exports; Senegal reinforces the role of women in trade by providing support to women entrepreneurs under the Senegalese agency for export promotion; and gender is Sweden's overarching thematic priority in its aid for trade activities.

28. Nevertheless, the gender impact assessments of the World Trade Organization (WTO) agreements are not fully used to influence trade negotiations. Women are often underrepresented in such negotiations, especially in the delegations of developing countries. In this regard, Pacific Island countries are currently carrying out a trade-related impact assessment on human rights and the United Nations Conference on Trade and Development (UNCTAD) has completed gender impact assessments of trade liberalization policies in Bhutan, Cape Verde and Lesotho.

29. Harnessing the full potential of trade for development requires addressing the gender-specific constraints in trade and increasing trading opportunities for women. Multilateral development assistance frameworks, including the Aid for Trade initiative, the Enhanced Integrated Framework for Trade-Related Technical Assistance to Least Developed Countries and the United Nations Development Assistance Framework, provide entry points to integrate gender issues in international trade. Furthermore, women negotiators need to be actively involved when the Doha Round of trade negotiations resumes.

[21] International Labour Organization and the Asian Development Bank, *Women and labour markets in Asia: Rebalancing for gender equality* (Bangkok, 2011).

[22] "Aid for trade: A gender dimension", powerpoint presentation by E. Lammersen, Organization for Economic Cooperation and Development, Gendernet, 8th meeting, June 2010 (http://www.oecd.org/dataoecd/57/8/45523507.pdf).

IV. Work and employment

30. Women's participation in the labour market has increased: between 1980 and 2009, the global rate of female labour force participation rose from 50 per cent to 52 per cent, and the male rate fell from 82 per cent to 78 per cent. These changes reflect the trend among the young, both young women and young men, to study longer. As a result, rates of participation of men and women in the labour force have narrowed, worldwide, from 32 percentage points in 1980 to 26 percentage points in 2009.[3]

31. Gender differentials remain large in some regions and substantial barriers to the participation of women in the labour market still exist. The rate of women's participation in the labour force is lower, at 26 per cent, in the Middle East and North Africa region than in any other part of the world and the proportion of unemployed women remains higher than that of men.[23] In Latin America and the Caribbean female labour force participation has increased over recent decades,[24] but women's participation is still limited by discrimination, lack of public childcare services, and the burden of unpaid work.

32. There are significant and systemic differences between men and women's jobs. Only a small proportion of employed women work in industry worldwide (18 per cent compared to 26 per cent of all employed men). Women are more likely than men to work in the agriculture (37 per cent of all employed women compared to 33 per cent of all employed men) and in the service sector (46 per cent of all employed women compared with 41 per cent of men's employment).[25] Within sectors, firms and occupations, women and men are concentrated at different levels of the labour hierarchy. Women's advancement to more senior and managerial positions is hampered by power relations and institutional barriers, including norms and attitudes.[26] In the Middle East and North Africa region this is described as the "concrete ceiling" — women have to work twice as hard to prove that they are as flexible and as good at their jobs as their male colleagues.[27]

33. In the current global economic conditions finding employment is increasingly difficult in many countries. In 2010 the global unemployment rate stood at 6.2 per cent with the unemployment rate for men at 6 per cent and for women at 6.2 per cent.[25] Initially the male dominated sectors, finance, construction, transport and manufacturing, were most affected by the crisis. However, as the global downturn evolved, job losses affected both women and men equally.[28] Young women and men have been particularly affected by the crisis; in the 56 countries with available data,

[23] See United Nations Development Programme, *The Arab Human Development Report 2005: Towards the Rise of Women in the Arab World* (New York, 2006).

[24] See GTZ, the World Bank and the Inter-American Development Bank, *Women's Economic Opportunities in the Formal Private Sector in Latin America and the Caribbean: A Focus on Entrepreneurship* (Washington, D.C., 2010).

[25] See International Labour Organization, *Global employment trends for women* (Geneva, March 2009).

[26] See International Labour Organization, "Breaking Through the Glass Ceiling: Women in Management" (Geneva, 2004).

[27] www.executive-magazine.com, "Women in business — Breaking glass: Six Arab women executives on gender, careers and life", ISSN No. 96 (July 2007).

[28] International Labour Organization, "Global economic crisis, gender and work: key policy challenges and options", Global Jobs Pact, Policy Brief 15 (Geneva, 2010).

there are 1.7 million fewer youth in the labour market than expected, a fact that would indicate rising discouragement among youth. In the South-East Asia region young people are five times more likely to be unemployed than adults, and they are frequently underemployed.[29]

34. All over the world women are less likely to have access to decent work than men. Data show that women are disproportionately concentrated in "vulnerable"[29] forms of work; they are concentrated in low-productivity jobs; they earn less; and they do disproportionate amounts of unpaid domestic labour and family care work. Women are disproportionately represented in informal work.[30] In Latin America and the Caribbean, for example, women are employed in more insecure and informal occupations, such as part-time jobs, which are held by 28 per cent of employed women compared to 16 per cent of employed men. The majority of women are employed in low-productivity sectors, earning scant wages with less access to social protection.

35. Evidence from 83 countries shows that women earn between 10 and 30 per cent less than men.[31] In the United Kingdom, for example, the gender wage gap (median full-time hourly pay) stood at 10 per cent in 2010. Gender wage gaps reflect disadvantages in education; bargaining power and labour market mobility and flexibility; a high degree of involvement in part-time, temporary and low-income jobs; and direct discrimination. Worker qualifications and job characteristics do not completely explain gender wage gaps; studies of gender-wage differentials suggest that some of the difference between men and women's earnings is due to direct gender discrimination.[3]

36. Member States are increasingly focusing on measures to reduce the gender wage gap. The United Kingdom has eliminated pay secrecy clauses in employment contracts since October 2010. It has also asked organizations, particularly those with 150 or more employees, to report equality data about their workforce on a voluntary basis. In the Sudan, equal pay for work of equal value is the law. In Morocco, in 2005, the Ministry of Justice established a gender unit to reduce gender disparities in employment and to ensure equality of wages and access to resources.[32]

37. The increased participation of women in paid work has not, however, been accompanied by a reduction in their unpaid work. Cutbacks in expenditures on the provision of essential services and the introduction of user fees in sectors such as education, health, water and sanitation have pushed those who cannot afford to pay into a greater degree of dependency on the unpaid labour of women and girls. Evidence from Argentina, India, Nicaragua, the Republic of Korea, South Africa and the United Republic of Tanzania shows that women generally have longer working days, when both paid and unpaid work was counted, and that the amount of unpaid

[29] According to ILO, vulnerable employment is measured as the proportion of self-employed workers and contributing family members in total employment (see http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets/econ_development/vulnerable_employment.pdf).

[30] See International Labour Organization, *Equality at Work: Tackling the Challenges*, report of the Director-General (Geneva, 2007).

[31] International Labour Organization, *Global Wage Report 2008/09: Minimum wages and collective bargaining. Towards policy coherence* (Geneva, 2008).

[32] Morocco, Ministry of Economy and Finance, *Gender Report* (Rabat, 2008) (see www.finances.gov.ma).

work performed increases when there was a young child in the house.[33] Similarly, time-use data from the Latin America region suggest that while the number of hours that women and men spend on unpaid domestic work and paid work can vary widely across countries, women's total work time is greater than that of men, and that women spend a larger share of their time on unpaid work than men in all cases. Evidence from high-income countries shows men spent a longer period of their working day in market-oriented work, while women spent more time than men cooking, cleaning and providing childcare.[34] In all of the countries covered, except the Nordic countries, combined market and non-market work resulted in longer working days for women.

38. Many countries have invested in public infrastructure, including water, transportation and energy, in order to reduce the burden of domestic work, including caregiving, within households. Running water and the use of electrical appliances can also reduce the amount of time and energy spent in these areas. UNDP has supported multifunctional platforms, consisting of a diesel engine and various associated tools such as grinding mills, huskers, alternators, battery chargers, pumps, welding stations and carpentry equipment, which have benefited approximately 2,000 villages in Benin, Burkina Faso, Ghana, Guinea, Mali, Niger, Senegal and Togo. Their use has reduced the amount of time women spend on domestic work by two to four hours a day. IFAD has supported projects in Kenya and Mozambique, and Japan has supported a similar project in Senegal, to improve women's access to water and reduce their workload.

39. The reliable and affordable provision of care facilities and services for children, the sick and older persons, as well as access to affordable education, can facilitate the reconciliation of work and family life. Governments in many countries have encouraged the private sector and non-governmental organizations to become active providers, granting subsidies to care providers or income allowances to parents in order to make childcare services more affordable. The Governments of Argentina, Chile, the Republic of Korea and Uruguay have moved towards more comprehensive provisioning of care services, extending services and experimenting with financing and delivery mechanisms. In Spain, where compulsory education starts at age 6, early school education (3 to 5 years) is free and 95 per cent of children above the age of 3 attend school.[35] Poland's Act on "Care for children under three" forces companies to create crèches for employees. Italy makes care services a priority in its structural and rural development policies.

40. Initiatives also focus on increasing men's involvement and skills in caregiving. A well-documented programme involving young men has been developed by "Programa H" in Brazil and Mexico, using workshops, videos and manuals on

[33] Budlender, D., "The Statistical Evidence on Care and Non-Care Work across Six Countries", United Nations Research Institute for Social Development, Gender and Development Programme Paper No. 4, December 2008.

[34] Razavi, S., and Staab, S., "The Social and Political Economy of Care: Contesting Gender and Class Inequalities", paper prepared for the Expert Group Meeting on "Equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS", organized by the former United Nations Division for the Advancement of Women, Geneva, October 2008.

[35] Beneria, L. and Martínez-Iglesias, M., "The New Gender Order and Reconciliation Policies: The Case of Spain", paper presented at the conference on the theme "Towards gender equality in the labour market: work-family life reconciliation policies", Istanbul Technical University, 27 May 2009, organized by Women for Women's Human Rights.

fatherhood, caregiving and HIV/AIDS to promote change in attitudes and behaviour.[36] The Sonke Gender Justice Network in South Africa uses innovative approaches to strengthen men's capacity and commitment to care for children, including orphans, affected by HIV/AIDS in rural areas.[37] An innovative project by Africare in Zimbabwe trained 120 men, aged between 20 and 65, as volunteer caregivers to increase men's participation in home-based care and HIV/AIDS education.

41. Securing more jobs, and decent jobs, adequate work conditions and sustainable livelihoods is particularly difficult for women in informal work.[38] Where employers draw on a labour force that has very few alternatives, they are able to pay exploitative wages, disregard employment laws and perpetrate violent acts on women, who usually cannot access complaint mechanisms or obtain legal aid to redress abuses.[39]

42. The lack of women's rights in the informal labour sector is reflected in how workers' rights are expressed and enforced by national and local law and practice, including whether enterprises are registered and whether they observe regulations governing business activities.[40] Labour inspection services in many developing and transition countries are not adequately staffed or trained, including in gender-sensitivity, nor are they equipped to effectively enforce standards, especially for micro and small enterprises and home-based and domestic workers.[40] Innovative schemes to evaluate workers' rights in the informal sector involve labour inspections, trade unions and workers themselves. In the State of Gujarat in India, for example, the Self-Employed Women's Association assists in monitoring the conditions of homeworkers and establishing minimum piece-rates consistent with the minimum wage.[40] In the Sudan, women working in the informal sector have formed associations to cover their health needs.

43. Implementing policies with no or little information on women working in the informal sector is difficult, especially since they are usually not enumerated in national employment or enterprise surveys. The South Asian Association for Regional Cooperation Business Association for Home-based Workers (SABAH) initiative, in Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan and Sri Lanka, has mobilized 3,000 home-based workers to access decent work opportunities and markets for their products. The SABAH initiative has been instrumental in establishing fair wages for the piece-rate work of its home-based members, and they are represented on its board.

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[36] Barker, G., Engaging men and boys in caregiving: reflections from research, practice and policy advocacy in Latin America, prepared for the Expert Group meeting on "Equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS", organized by the former United Nations Division for the Advancement of Women, Geneva, October 2008.

[37] Esplen, E., *Gender and Care: Overview Report*, BRIDGE (London, 2009).

[38] Chant, S. and Pedwell, C., *Women, gender and the informal economy: An assessment of ILO research and suggested ways forward* (ILO, Geneva, 2008).

[39] United Nations, *2009 World Survey on the Role of Women in Development: Women's Control over Economic Resources and Access to Financial Resources, including Microfinance* (New York, 2009).

[40] International Labour Organization, *Decent work and the informal economy*, Report VI, 90th Session of the International Labour Conference (Geneva, 2002).

44. Certain groups of women, including indigenous women, women with disabilities, women refugees, women in post-conflict settings and migrant women, face additional constraints in the labour market. Women represent half of the world's 215 million international migrants,[41] as well as a growing percentage of internal migrants who move from rural to urban areas — in China alone there are 200 million rural to urban migrants,[42] and a significant number of these are young women concentrated in the manufacturing and service sectors.[30] Women and girls disproportionately face rights violations at every stage of the migration cycle, including sexual and gender-based violence and discrimination, migrant smuggling and trafficking in persons and exploitation by employment agencies and employers. They lack access to social protection, reliable information on safe and legal migration, social services, woman-friendly remittance transfer mechanisms and savings and investment schemes.

45. Hiring domestic workers is a growing trend in all parts of the world for families seeking to reconcile household responsibilities with the demands of employment. Many domestic workers do not have formal contracts and receive no social insurance.[14] The hidden nature of domestic work makes it more difficult to enforce legislation.[43] ILO estimates that the number of domestic workers worldwide could be as high as 100 million, and data from 18 developing countries reveal that domestic work is 4 to 12 per cent of wage employment.[44] Between 74 and 94 per cent of domestic workers are women.[45]

46. Argentina, Chile and South Africa have legislated to provide basic labour and social rights for domestic workers. Since 2002, domestic workers in South Africa, for example, have been guaranteed minimum wages that are periodically adjusted to match inflation rates, including paid leave, overtime payments and severance pay. Employers are required to register domestic workers with the national Unemployment Insurance Fund and pay contributions, making them eligible for unemployment and maternity benefits.[43] In Lebanon, a unified contract, developed by a Lebanese steering committee in cooperation with the Office of the United Nations High Commissioner for Human Rights (OHCHR) and ILO, is now in place to protect the human rights of women migrant domestic workers.[46]

47. The International Training Centre of ILO (ITC-ILO) offers capacity-building courses on maternity protection, women's entrepreneurship and gender mainstreaming and develops gender auditing tools targeting Governments, workers' and employers' organizations and other development partners. The United Nations Educational, Scientific and Cultural Organization (UNESCO) Antenna in Juba, South Sudan, initiated a project on creating opportunities for youth employment, focusing on training activities for young girls in reading, writing, food processing, crafts, tailoring, needlework and sewing.

[41] International Organization for Migration, *World Migration Report 2010 — The Future of Migration: Building Capacities for Change* (Geneva, 2010).

[42] Chinese Floating Population Development Report 2010 (see http://www.gov.cn/jrzg/2010-06/26/content_1638133.htm).

[43] International Labour Organization, "Work and family: The way to care is to share!", theme of the Gender Equality at the Heart of Decent Work Campaign, 2008-2009.

[44] ILO estimates the number of domestic workers in 117 countries at around 53 million, based on national surveys and/or censuses.

[45] UN-Women, *Progress of the World's Women: 2011-2012. In Pursuit of Justice* (New York, 2011).

[46] http://www.ohchr.org/EN/NEWSEVENTS/Pages/UnifiedContractLebanon.aspx.

V. Women entrepreneurs

48. Setting up in business can enable women to gain economic independence, overcome poverty and increase their well-being. While women are found in a range of entrepreneurial activities, many are concentrated in micro-, small- and medium-sized businesses as a result of unpaid work burden, limits on mobility, lack of collateral and limited financial skills. Women often go into survivalist or needs-driven entrepreneurship, as opposed to more lucrative businesses because of a lack of options and insufficient well-paid wage employment.

49. A UNDP assessment in 34 African countries found that the persistent concerns of women entrepreneurs were: lack of access to finance and productive resources; lack of access to international trade; the high cost of doing business; the difficulty of organizing as entrepreneurs for advocacy with Governments and other organizations; and insufficient entrepreneurial skills.

50. In Eastern Europe and Central Asia region, where women are still underrepresented among business owners and managers, 36 per cent of firms have female participation in ownership and 18.7 per cent have top female managers.[47] In Afghanistan, only 6 per cent of women ran businesses in 2004.[48]

51. Women's entrepreneurship in the Middle East and North Africa region, where 20 per cent of firms have female participation in ownership,[49] remains low compared to other regions.[50] The share of female-owned firms varies from nearly 30 per cent in Lebanon, to 20 per cent in Egypt to just 10 per cent in Morocco. Yet female-owned firms are as well established, productive, technologically savvy and connected to global markets as male-owned firms, and more than 65 per cent of female-owned firms are managed by the owner. Despite this evidence, only 13 per cent of 4,832 firms surveyed in the eight countries of the region were owned by women.[51] While there are no significant differences in the types of firms owned by women and men, women face a more hostile business environment.

52. It is, however, possible for women to be successful entrepreneurs if enabling policies and institutions are in place. Enhancing the competitiveness of women's businesses can be critical to link women to global markets. For example, the programme organized by the United Nations Development Fund for Women (UNIFEM) (now UN-Women) for women producers in Burkina Faso resulted in increased production of shea butter that met world commercial quality standards, increased skills in sales, negotiation, marketing techniques, and the use of information and communications technology (ICT), and increased knowledge of and access to financial services.

53. The conference on "Women's economic empowerment", organized by the Canadian International Development Agency and UN-Women in Ottawa in October

[47] Contribution of the Economic Commission for Europe.

[48] Based on the contribution of the UN-Women Afghanistan country office.

[49] Compared to figures reported by the World Bank of 33 per cent in East Asia and the Pacific, 39 per cent in Latin America and Caribbean and 29 per cent in sub-Saharan Africa.

[50] No Arab State has a share higher than the world average of 29.2 per cent. The only Arab State with a share of full-time women workers higher than the world average of 27.4 per cent is Morocco, at 40 per cent. The regional average is 16.2 per cent.

[51] World Bank, "The Environment for Women's Entrepreneurship in the Middle East and North Africa Region" (Washington, D.C., 2007).

2011, highlighted the need to support women entrepreneurs in addressing the challenges of globalization, competing in global markets and moving higher up the value chain. Networking among women entrepreneurs through personal contacts, trade shows and links between women's associations and enterprises in a value chain was considered critical for the development of women's entrepreneurship.

54. Responses highlighted initiatives that support women entrepreneurs, through training programmes, workshops, conferences and microcredit initiatives (for example, in Colombia, Djibouti, Latvia, South Africa and Turkey, and by UNDP, UNFPA, the Economic Commission for Europe, UNESCO, UNHCR and UN-Women). Initiatives in South Africa ranged from supporting women's entrepreneurship through various on-demand business development services and by providing easy and affordable access to finance and ICT solutions. The Social Fund for Development in Djibouti has provided microfinancing to women entrepreneurs.

55. The ILO Women's Entrepreneurship Development programme works with Governments, employers' organizations, trade unions and local community-based organizations to create an enabling environment for women's entrepreneurship development that generates quality jobs, builds institutional capacity in this area and develops tools and support services for women entrepreneurs.

56. The Economic Commission for Europe addressed the development of women's entrepreneurship by: improving awareness of the situation of women entrepreneurs through research, data collection and policy dialogue; building capacity for women's entrepreneurship development; and encouraging gender-sensitive economic policymaking.

57. While these initiatives contribute to the development of women's entrepreneurship, an integrated approach is needed to create an enabling environment for sustainable enterprise development, social dialogue and investments in basic education, health and physical infrastructure. Organizations, such as the Self-Employed Women's Association (SEWA) and Homenet, which help women entrepreneurs organize themselves into cooperatives and networks, should be supported.

VI. Economic decision-making

58. A major constraint on women's economic empowerment is their absence from the forums in which decisions are taken that impact, directly or indirectly, the distribution of economic and financial resources. Globally, the representation of women in national parliaments averages 19 per cent (17 per cent of ministers). The critical 30 per cent mark for women's representation at the national level has been reached or exceeded in 28 countries, 23 of which have used quotas to achieve that goal.[52] Women are similarly excluded at local levels of government in many countries. For example, in Melanesian countries, even though taxes paid by women vendors in local markets provide most of the finances for the local town councils,

[52] According to information from the International Institute for Democracy and Electoral Assistance, Stockholm University, and the Inter-Parliamentary Union (2010).

women have no voice there, nor in decisions relating to management of markets, infrastructure and security services in the markets.[53]

59. Once in power women are not accorded equal access to all aspects of government. Ministers of the 27 States Members of the European Union, for example, were found to hold portfolios relating to socio-cultural functions (36.7 per cent), including social affairs, health, children, family, youth, older people, education, science, culture and sports, rather than portfolios relating to the economy (17.7 per cent), finance, trade, industry or agriculture.[54] In Indonesia, on the other hand, both the minister of trade and the minister of national development planning are women.

60. Women are also underrepresented in management positions in both public and private sectors around the world. Despite making up nearly half of the workforce and accounting for 60 per cent of new university graduates in the countries of the European Union, women make up less than a third of business leaders. The difference between the percentage of women business leaders and the share of women in the total workforce is greatest in Cyprus and Finland (both over 30 per cent) and lowest in Greece, Spain and Italy (all below 10 per cent). The latest statistics show that a typical board of 10 has just one female member, and that in 97 per cent of cases the board is chaired by a man. In 2010, women accounted for just below 12 per cent of board members in the largest publicly listed companies in the European Union, and for just over 3 per cent of board chairs.

61. The private sector can play a critical role in promoting women's economic empowerment. Germany's 30 biggest publicly listed companies have announced targets for promoting women without the introduction of a mandatory quota. The quota introduced by Norway has increased the representation of women on the boards of large Norwegian companies from 22 per cent in 2004 to 42 per cent in 2009. Sweden and Finland have introduced corporate codes that stress the importance of diversity and gender equality.[55] There is one woman member for every three men in Sweden and Finland, while figures for Latvia, Slovakia and Romania are only slightly lower. In Malta, Luxembourg, Cyprus and Italy, fewer than 2 per cent of board members are women. The situation is not very different in the United States of America, where women hold around 15 per cent of board seats in the Fortune 500 companies and chair 2 per cent of boards.

VII. Evidence and data

62. Better evidence is needed to design the policies that will increase women's economic empowerment and data are needed to analyse the gender-specific impacts of macroeconomic and trade policies. Another fundamental constraint is incomplete information about the value and extent of unpaid work that produces the goods and services families and communities rely on for their well-being and survival. Another is the unavailability of gender-disaggregated data, for example, on income and asset

[53] Based on contribution of the UN-Women Pacific subregional office.

[54] European Commission, *Women and men in decision-making 2007: analysis of the situation and trends*, Directorate-General for Employment, Social Affairs and Equal Opportunities (Luxembourg, 2008).

[55] European Commission, *Report on Progress on Equality between Women and Men 2010: The gender balance in business leadership* (Luxembourg, 2011).

ownership, as well as on variables that indicate women's ability to participate in economic decision-making.

63. Since 1998, 18 countries in Latin America and the Caribbean have produced time-use data with a gender perspective. A classification of time-use activities for Latin America and the Caribbean, currently in the final stages of review, was developed during the international expert group meeting on time-use surveys in 2009.[56] It was welcomed at the 2011 Statistical Conference of the Americas, where Member States were invited to make use of the proposed classification system and convey their comments, with a view to harmonizing time-use surveys in the region. Japan has been conducting time-use surveys every five years since 1976.

64. The Division for Gender Affairs of the Economic Commission for Latin America and the Caribbean provides technical support to the production of statistical information with a gender focus. The increased demand for technical assistance demonstrates that Member States want to improve in the collection of gender statistics and to use the data gathered for policymaking. The user-producer strategy promoted by the Division for Gender Affairs has advanced the use of positive synergies between the national statistical bureaux and national mechanisms for gender equality. The Statistical Division of the Economic Commission for Europe provides capacity-building on gender statistics to national statistical offices in Eastern and South-Eastern Europe, the Caucasus and Central Asia. The Commission also published a handbook on gender statistics in 2010, in both English and Russian, and training videos on 11 key topics in gender statistics have been developed in cooperation with the World Bank.

65. The United Nations System of National Accounts (SNA) of 1993 sets the standards for the measurement and classification of economic activities. It classifies most activities done by women (including cooking, cleaning and caring for children) as non-economic, thereby falling outside of the SNA boundaries, but it recommends that such activities be recorded in parallel — or satellite — accounts. The increased availability of time-use surveys has enabled the construction of additional satellite accounts, the one in Mexico being a recent example. Generally, however, data are still lacking and more work is needed on global standards and definitions. There is much to be done before the importance of measuring unpaid care work is acknowledged and fully integrated into national statistical systems.[57]

66. The Inter-agency Expert Group on Gender Statistics has developed a minimum set of gender indicators that will be presented to the United Nations Statistical Commission for endorsement by Member States at its forty-third session in February 2012. The Group proposes indicators in the following domains: economic structures and access to resources; education; health and related services; public life and decision-making; and human rights of women and girl children. The Expert Group recommends strengthening data collection instruments, especially household surveys, to fully reflect critical gender issues, and developing time-use surveys and data collection on violence against women and on entrepreneurship and women's economic empowerment. In response, UN-Women and the United Nations Statistics

[56] An annual meeting organized by the National Women's Institute and the National Institute on Statistics and Geography of Mexico, along with the Economic Commission for Latin America and the Caribbean and UNIFEM (now UN-Women).

[57] See International Labour Organization, *Global Employment Trends 2011: The challenge of a jobs recovery* (Geneva, 2011).

Division are currently working on a new initiative that seeks to harmonize existing gender statistics and sex-disaggregated data in employment, education and entrepreneurship and to coordinate and advance efforts to collect sex-disaggregated economic data, while ensuring country ownership.

VIII. Conclusions and recommendations

67. **Slow recovery from the financial and economic crisis, increased economic uncertainty, high unemployment and prolonged instability in the food and fuel markets permeate the global economy and affect all nations and people's well-being at different levels. Global policy responses need to recognize women's economic empowerment as an essential part of the solution to achieving balanced and sustainable global growth, with equality and justice and dignity for women and men.**

68. **Macroeconomic policies, if they are gender-responsive, can create the enabling environment for women's economic empowerment. Despite repeated initiatives to advance women's economic empowerment, there has been no coherent or systematic approach to address constraints to women's economic empowerment in macroeconomic policies and international trade policies.**

69. **While progress has been made in increasing women's access to employment, efforts are needed to strengthen institutions and equip them with the skills and resources to implement policies that accelerate women's economic empowerment and ensure workers enjoy the right to decent work. One critical area is the regulation of work and employment conditions of the most vulnerable workers, typically those employed in the informal sector, including home-based workers, domestic workers and migrant workers. Additional measures are also needed to enhance gender equality in the workplace.**

70. **Member States and other stakeholders are encouraged to consider the following policy measures and actions to advance women's economic empowerment:**

(a) **Evaluate the gender-impact of macroeconomic policies, in particular the policy responses adopted as a response to the financial and economic crisis;**

(b) **Develop and improve the use of sex-disaggregated data and gender statistics on women's economic empowerment; strengthen data collection instruments, especially household surveys, to fully reflect gender issues; develop time-use surveys and data collection on women's economic empowerment, including employment and work, and on entrepreneurship;**

(c) **Systematically monitor and evaluate programmes geared towards women's economic empowerment for results and impact on women's lives;**

(d) **Enhance women's agency in trade negotiations and ensure that trade agreements and trade liberalization processes are gender-responsive;**

(e) **Reduce the burden of unpaid work through investment in infrastructure and services;**

(f) **Create incentives for informal enterprises to formalize, including through simplified registration procedures and progressive registration fees and legal recognition of property rights;**

(g) **Remove the barriers to women's participation in the labour market, strengthen institutions and enact the reforms needed to secure decent working conditions.**